How To Get Your Slice of the Stimulus Pie

By now you’ve heard about the $787 billion American Recovery and Reinvestment act of 2009 - the stimulus bill recently passed by Congress. The bill is aimed at spurring economic growth across multiple industries by way of government spending. What’s in it for you?

Well if you are a healthcare provider, you can take advantage of the $51 billion that has been allocated to the health care industry, $19 billion of which will be used to incentivize medical practices to adopt and implement Electronic Health Records (EHRs).

How does the subsidy work?

Starting in 2011, providers deemed to be “meaningful users” of EHR systems will be eligible to receive $40,000 - $60,000 in incentive payments paid out over five years in the form of increased Medicare and Medicaid premiums.

For the first year a physician is deemed to be a meaningful user, he or she will be eligible for payments of 75% of that year’s Medicare and Medicaid charges, up to a maximum of $15,000. The maximum payment is increased to $18,000 if the first year is 2011 or 2012. The incentive payments decline for each subsequent year within the five-year period; $12,000 will be paid in year two, $8,000 in year three, $4,000 in year four, and $2,000 in year five.

No incentive payments will be available after 2015, and no payments will be offered to physicians who first become eligible after 2014. This creates a decreasing incentive for late adopters.

What is a “meaningful user”?

To qualify as a “meaningful user,” eligible providers must demonstrate use of a “qualified EHR” in a “meaningful manner.” The bill defers to the secretary of Health and Human Services (HHS) to set specific guidelines for determining what constitutes a “qualified EHR,” however, it does specify that e-prescribing, electronic exchange of medical records, and interoperability of systems will be determining criteria.

HSS will be working throughout 2009 to set the necessary criteria for certifying systems, and is expected to have a final report by January of 2010. Many expect CCHIT (Certification Commission for Healthcare Information Technology) certification to play a major role in setting standards of interoperability. After all, HHS funded the creation of CCHIT in 2004 to start certifying EHRs against a minimum set of requirements for functionality, interoperability and security.

How do I qualify for the maximum payment?

In order to receive the maximum payment, physicians must qualify as a meaningful user in 2011. Eligible

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Continued from page 1

physicians will receive a first year bonus of $18,000 (up from $15,000) and will max out the payment schedule over the next five years. The table below illustrates the amount of a subsidy paid each year (columns) based on the year the provider first becomes eligible (rows):

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No payments will be offered to physicians who first become eligible after 2015. Practices with multiple physicians will be eligible to receive incentive payments for each provider. Remember that payments will be based on 75% of the correlating year’s Medicare and Medicaid charges. Therefore, in order to qualify for the maximum payment of $18,000 in the first year, each provider must bill Medicare or Medicaid a minimum of $24,000.

Should I purchase an EHR now or wait until 2010? An obvious concern is whether an EHR implemented in 2009 will meet the standards set by HHS in 2010. Although a legitimate concern, waiting until 2010 to implement a system may be a mistake. Researching and selecting the right EMR can be a lengthy process, and many providers who wait may find it difficult to have a system in place in time.

Practices would be well-served to begin the research process now, allowing ample time to create a short-list of systems, perform demos with several vendors, check references, meet with vendors in person, negotiate terms, and for “qualified EHRs.” While there are many opinions for and against CCHIT, we expect it to play a critical role in the EHR subsidy qualification.

What if I choose not to purchase an EHR? Unfortunately, for physicians who choose not to implement an EHR, the stimulus bill is a double-edged sword. Not only will they forego thousands in incentive payments, but starting in 2015, they will be penalized by way of decreased Medicare and Medicaid payments. Physicians who fail to qualify as meaningful users will face decreases of 1% in 2015, 2% in 2016, and 3% in 2017, with a maximum reduction of 5% by 2020.

Bottom Line: Although each physician’s individual situation will dictate whether or not they choose to implement an EHR, the unique opportunity offered within the stimulus bill should not be overlooked.

David Jackson of Medical Software Advice (www.softwareadvice.com) can be reached by phone at (415) 449-0555 or by email at davidj@softwareadvice.com.

Collaborative Program at Abington Advances Care for Liver and Pancreatic Patients

When a young man came to Abington Memorial Hospital with chronic pain and a large mass in the head of the pancreas, he needed complex and sophisticated treatment like many patients with hepatobiliary and pancreatic tumors. But instead of being transferred to a downtown hospital, he received the advanced care he needed in The Rosenfeld Cancer Center at Abington Memorial Hospital.

Having his treatment closer to home was possible due to an innovative new program that teams Abington surgeons, medical oncologists, interventional radiologists and gastrointestinal specialists with liver, pancreas and biliary surgery experts from the Drexel University College of Medicine. Together, doctors from both institutions performed a complicated Whipple procedure to restore the young man’s health and the patient recuperated at Abington.

As Abington has grown from a small community hospital to a 570-bed institution serving a broader region of suburban Philadelphia, we’ve developed our services to provide patients with the expertise they need. Out of that philosophy, we determined that expanding our surgical program in liver and pancreatic diseases would enable our patients access to the most advanced care.

We created the Hepatobiliary and Pancreatic Surgery program at Abington in conjunction with Drexel specialists. The program is led by William Meyers, MD, an Abington physician, professor and chairman of Drexel’s Department of Surgery, and a national expert on liver and pancreatic surgery. Other specialists in the program include David Reich, MD, and chairman of Drexel’s Department of Pathology.

Having his treatment closer to home was possible due to an innovative new program that teams Abington surgeons, medical oncologists, interventional radiologists and gastrointestinal specialists with liver, pancreas and biliary surgery experts from the Drexel University College of Medicine. Together, doctors

The Stimulus: Supporting NIH and Information Technology

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The stimulus legislation calls for standards to be developed for the nationwide electronic exchange and use of patient health information by 2010. Much of the money will support IT infrastructure along with Medicare and Medicaid incentives to encourage doctors, hospitals, and other providers to switch to electronic record keeping. Special provisions will strengthen Federal laws to protect the privacy and security of patients’ electronic records.

The Congressional Budget Office estimates that 90 percent of doctors and 70 percent of hospitals will switch to certified electronic health records within the next decade. In turn, that will save the government more than $12 billion through reduced spending on Medicare, Medicaid and other programs.

I believe the stimulus investments in health information technology and biomedical research will have a profound impact on the future practice of medicine and I will work to make sure that patients and physicians share in the benefits this legislation provides.

Arlen Specter is a Republican senator from Pennsylvania.

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Collaborative Program

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M.D., Burkhardt Ringe, M.D. and Gary Xiao, M.D.

This new program brings a full spectrum of services to Abington patients facing treatment for tumors, blockages and other conditions of the liver, pancreas or biliary system. Nearly all procedures—with the exception of liver transplants—are handled at our main campus in eastern Montgomery County, so patients benefit from the comfort of being close to their families and medical providers. A nurse navigator also helps by coordinating testing and appointments in what can be very complicated care.

At the heart of this new program is a powerful collaborative spirit. Drexel physicians maintain an office at Abington to see patients; doctors from both institutions join in a weekly videoconference to review cases and a monthly soft-tissue tumor conference. These joint consultations help us all. I’ve been practicing for 20 years, but recently when I saw a patient who had a cystic lesion in the body of the pancreas. I decided to present his case at the next conference where I could get three or four more opinions. Something good always comes out of such discussion, even when the other physicians agree with me.

A patient, treated for lung cancer at Abington five years ago, was diagnosed in a follow-up CT scan with a spot on his liver. We determined that he would benefit from a liver transplant, so the Hepatobiliary and Pancreatic Surgery program streamlined the process of getting him the needed transplant at Drexel. He is now doing well.

In addition to such successes, the program has generated more chemoembolizations of the liver, laparoscopic liver operations, radiofrequency ablation (RFA) for liver lesions, intraoperative ultrasounds in liver and pancreatic procedures, and major hepatic resections—including a recent trisegmentectomy that removed 73 percent of a patient’s liver.

This collaboration provides Abington patients with the most comprehensive care for cancer and other serious conditions of the liver, pancreas and bile ducts. As this area of surgery has evolved rapidly, we are able to offer the full armamentarium of procedures within our growing community. We are also privileged to have been named a Blue Distinction Center for Complex and Rare Cancers by Blue Cross Blue Shield companies which further reinforces the hospital’s expertise in oncologic care.

Christopher M. Pezzi, MD is the Director of Surgical Oncology at Abington Memorial Hospital.

Abington and Drexel specialists have created the Hepatobiliary and Pancreatic Surgery program, which will provide patients with the most comprehensive care for cancer and other serious conditions of the liver, pancreas and bile ducts.

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PERSONAL FINANCE

Retirement Plans in the New Decade: Required Amendments and Design Opportunities

Unless you invested your pension and profit sharing plan funds in certificates of deposit, you have most likely lost anywhere from 30-to-50% of the value of your accounts over the last six months. We all hope that the economy and the market eventually improve so we can recoup some of those losses.

In the meantime, although the upcoming required amendments to most retirement plan documents will add another one-time hefty administration expense, they also create a perfect opportunity to examine the design of your plan(s) to perhaps contribute more and save on non-physician owner contributions to help hasten the “reversal of fortune.”

First the bad news. Similar to the “GUST” pension and profit sharing plan restatements that all plans went through in 2001 through 2003, all plan sponsors will be required to completely amend and restate their retirement plan documents to comply with the final regulations issued in conjunction with the Economic Growth and Tax Relief Reconciliation Act of 2001 (“EGTRRA”). Updated documents must be prepared and executed by no later than April 30, 2010.

Among many other provisions, EGTRRA implemented the following pension plan amendments and restatements that all plans went through:

- Increased deemed contribution limits for 401(k) plans ($16,500 for 2009)
- New age 50+ “catch-up contributions” ($5,500 for 2009)
- Increased annual additions limit ($49,000 for 2009)
- Increased annual compensation limit ($245,000 for 2009)
- Increased tax deduction limits for employer contributions
- Permitted rollovers from IRAs to qualified plans

Along with the mandatory document amendments, each plan sponsor/employer has the option to file with the Internal Revenue Service for an individual Favorable Determination Letter. Although it is not mandatory, it is strongly recommended that all restated plans and any non-standardized-prototype plans be submitted to the IRS for approval. This IRS approval letter signifies that the IRS approves the plan amendments and restatements of the plan design. It is important to have this letter upon an audit of the plan by the IRS and it may also be helpful when transferring plan assets to a new institution.

The following opportunities are available:

1. Add a 401(k) Feature to an Existing Profit Sharing Plan
2. Increased annual compensation limits
3. New age 50+ “catch-up contributions”
4. Increased tax deduction limits for employer contributions
5. Permitted rollovers from IRAs to qualified plans

Supplemental Pension Plans
Among many other provisions, the IRS does charge a “user fee” for the privilege of filing for a Determination Letter. The fees are as follows:

- The initial filing fee is $5,100 ($7,200 for “favored” plans)
- The fee for a favorable determination is $1,500 ($2,100 for “favored” plans)
- There is a 15.3% FICA tax obligation to be able to increase plan funding for the family unit.

Since the plan amendment process has a deadline and the design opportunities may be worthwhile, it is important to start investigating the possible changes as soon as possible. April 30, 2010 will be here before you know it and many plan consultants will be extremely busy late this year and early next year.

Jeffrey B. Sansweet, Esq. is a shareholder with the healthcare law firm of Kalogredis, Sansweet, Dearden and Burke, Ltd. in Wayne, Pennsylvania.

Recession Proof Estate Planning

Rose Ann received a panicked call from her daughter, Jennie.

“What are you doing Mom?” Jennie asked with a voice that sounded concerned.

“Nothing.” Rose Ann responded calmly.

Jennie blurted, “I don’t mean at the moment... What are you doing about the stock market collapse?”

Rose Ann continued, “I know what you are asking. I’m not doing anything, why?”

What she didn’t possess in stature—“five feet, four and three quarters inches” Rose Ann was always true to her word. She never broke her promise and always followed through. She always said what she meant and meant what she said.

“No, I’m not panicked. Why are you so nervous?” Rose Ann answered. Deep down, Rose Ann knew that Jennie really didn’t trust her to make decisions. Duke, who retired almost a decade ago, had always made the majority of the financial decisions throughout their entire sixty one years of marriage. Jennie didn’t know that Duke hadn’t been making all the decisions for almost eighteen months… but she refused to acknowledge that Dad’s dementia was that bad.

“My 401(k) account is down forty percent. I’m worried about our future... and I’m worried about you and Dad.” Jennie exclaimed trying to keep her voice from matching her feelings.

Rose Ann continued, “Jennie, your dad and I are fine. We made some decisions over a year ago that created additional reliable income for us. We have enough income for our lifestyle and health issues coming in every month for as long as we live... and we have created a legacy for you and the grandchildren... and we’ll be leaving a legacy to a couple of organizations that we care about deeply... the hospital and our alma mater.”

“You college?” Jennie interrupted somewhat rhetorically, having heard the stories of the old courtship during college and having seen their lifelong connection with the school and their former classmates.

“Yes. We went to a special presentation sponsored by the college a few years back and heard from a unique specialist. He said that your wealth is first about securing your lifestyle... then about your legacy to family and charity. He called it ‘legacy planning... living your legacy’. I just remember that the concept of reliable lifetime income equal to your lifestyle was really attractive to me... and then you don’t have to worry about the ups and downs of the stock market. Dad said that he had heard about some of these options, but never did anything about it. He had a demanding career, as you know, and tried to take care of our finances by himself. You know your dad, because he was so competent at his profession, he thought he was equally competent at managing our finances. Well, he wasn’t. You can’t master two professions at the same time... no one can. Well, anyway, it was all new to me... and it seemed very attractive considering our needs... lifetime income equal to our lifestyle.” Rose Ann continued.

“The specialist that spoke said that wealth planning must begin with lifestyle planning; then legacy. Well that resonated with me. Then he asked if we had a lifestyle plan... not one of those you-are-going-to-earn-X-each-and-every-year-for-the-rest-of-your-life projections you get from brokers, but a reliable lifestyle plan. Well, your father said we had everything taken care of. However, I knew that we didn’t... because he wouldn’t take the presenter up on a free second opinion. Why wouldn’t he get a second opinion... at no cost? So I said to him, ‘Duke, in the medical profession, if someone comes to see you 2, you show them that there are more options available to them then they were aware of... and they won’t get a second opinion from you... what do you always say?’ Duke answered without having to think, ‘They’re stubborn and scared... and stupid! I can’t help them unless they are open-minded. If they don’t want to know... let them keep their head in the sand.’ So I asked him straight up, ‘Duke, where’s your head?’ In the sand? Let’s at least explore the options.”

Rose Ann is not typical. She is not afraid to listen to something new and make changes. She has long since learned to watch successful people and do the things that...
The Physician’s Role in Quality Improvement

In the last thirty years, no area of hospital practice has received more attention than quality improvement programs (QIPs). Just as inventorying the different types of programs tried and abandoned during this time frame would be a daunting task, Government at all levels, business associations, and health-care practitioners themselves have advocated for programs just to see them go away and be replaced with another. Sadly, as reported by the Institute of Medicine, medical errors remain a major concern, and the area of patient safety needs to be foremost in the minds of caregivers.

Moreover, a study published in the Journal of the American Medical Association in June 2005 reported what many of us already suspected. Despite billions of dollars spent, organized quality improvement programs show little real and lasting impact. Even more depressing is a recent Joint Commission on Accreditation of Healthcare Organizations report that, despite increased attention, wrong site surgeries continue to increase.

Why is this the case? Why does health care, unlike, say, automobile assembly, resist structured process improvement? I do not pretend to have the definitive answer, but my experiences have certainly provided some clues.

The first, and perhaps the most important, factor in my view is the failure of organized medicine to evaluate and adopt a particular methodology and promote its use. Such practices as evidence-based medicine and clinical pathways have many adherents and are in wide use, but neither of these appears to provide the total answer to quality and process improvement, particularly in the complex environment of the hospital.

Regardless of whether an optimal methodology currently exists, the best clue to the failure of QIPs is the lack of physician leadership. With no major physician group leading the way, QIPs have been left to administrators, business coalitions, insurers, and regulators. None of these groups has the clinical knowledge to either develop these programs or actually implement the changes needed to improve the delivery of care. We must recognize the obvious fact that physicians, nurses, and other clinicians are the ones who actually take care of patients, and they are the ones who will either adopt or ignore a QIP.

It is a central tenet of change management that for people to actually support making changes, they must be deeply involved in the conceptualization and design of the change. Moreover, even though there is a great deal of emphasis on providing financial incentives to physicians to participate in these programs, physicians need to be cautious about doing anything that may cause patients to question their motives.

There is another aspect to quality and process improvement programs that is proving to be very controversial: that of employing financial incentives to motivate physicians to participate. Hospital executives are always looking for ways to partner with their medical staff members, but aligning the desire to improve care or reduce costs with money incentives has an unsatisfactory history. One only needs to remember when many health-maintenance organizations provided bonuses to physicians for reducing specialty referrals or numbers of expensive diagnostic tests, to see how the public, as well as legislative bodies, feel about this.

Although discussion regarding pay for performance and gain sharing is widespread, physicians are advised to be cautious in participating in these programs. Patients must not feel that their care providers are conflicted in making judgments regarding their health care needs, but rather must feel that physicians are willing and able to do what is best for them. Moreover, there is something troubling about letting the public think that physicians will only do what’s right when they are paid to do so.

We all agree that delivery of the highest-quality health-care services is our goal. Long lists of programs have been attempted with little lasting effect and a great deal of wasted effort and money. It is the responsibility of organized medicine and individual physicians to take charge of these efforts, or we will likely continue to lurch from program to program and not achieve the results we desire. This “flavor of the month” approach simply has not worked.

In the absence of medical leadership, QIPs have little chance of succeeding. Led by physicians who are true champions of quality improvement, programs are more likely to take root in the institutional setting. This seems so clear to me that I constantly wonder why there is not more organized physician leadership in this matter.

It is also worth noting the so-called Hawthorne effect. Simply put, this effect is a management concept first noted in the early 1900s. Management researchers in a manufacturing plant saw that any attention paid to workers caused all participants to more carefully perform their activities, and the process almost automatically became more efficient. Consequently, when attention was taken away from the process, performance fell back to previous levels.

The Hawthorne effect has been evident in health care for many years. Quality improvement programs always cause some improvement when they focus on a particular area. Unfortunately, the same reverse occurs: previous levels of performance takes place in health care as well. For us to make any lasting improvement, we must be unwavering in our commitment. To date, this has not happened except in isolated institutions where true physician champions exist. We need more of them!

Samuel H. Steinberg, Ph.D., FACHE

is the Senior Strategist at Health Strategies & Solutions, Inc.
Jefferson Collaboration Focuses on Connection between Reflux and Sleep Problems

For all too many Americans, a good night’s sleep is but a dream. However, evidence from a study by gastroenterologists and sleep specialists at Thomas Jefferson University Hospital could ultimately and safely put an end to those restless nights. The study has demonstrated that gastroesophageal reflux disease (GERD) may be responsible for sleep difficulties. Furthermore, while sleeping pills may help some patients sleep better, prescribing them for patients with GERD may have significant consequences with respect to esophageal health.

The study is a collaborative effort between the Jefferson Digestive Disease Institute’s Gastrointestinal Research Center and the Jefferson Sleep Disorders Center. The research team includes Anthony J. DiMarino Jr., MD, Professor of Medicine at Jefferson Medical College (JMC) of Thomas Jefferson University and Director of Jefferson’s Division of Gastroenterology and Hepatology; Karl Doghramji, MD, Professor of Psychiatry and Human Behavior at JMC and Director of the Jefferson Sleep Disorders Center; and Sidney Cohen, MD, Professor of Medicine at JMC and Director of Research in Jefferson’s Division of Gastroenterology and Hepatology. They and other researchers at JMC have been studying a group of subjects who have a history of sleeping difficulty but no medical problems that might cause such difficulty and no known history of GERD.

Common denominator

Acid reflux and insomnia are typically considered separate problems for most adults. Some 50 percent of American adults report having trouble sleeping at least once or twice a month. Fifty percent of the adult population has reflux at least once a month, about 20 percent once a week and about 10 percent every day. It turns out that the common denominator among a significant number of people who have trouble sleeping is not restless legs or anxiety, but rather gastrointestinal problems. When the lower esophageal sphincter doesn’t close properly, stomach acid can leak back into the esophagus, causing GERD and, as a result, heartburn.

“Together, esophageal reflux and sleep difficulties can be a recipe for trouble,” says Dr. DiMarino. “If the sphincter is open or not working, a reflux during sleep causes arousal, and the patient wakes up into a lighter sleep, changing the brain wave pattern. The person needs to swallow but must wake up to do so. The acid returns to the stomach, and the alkaline saliva raises the pH. Then, the person falls back to sleep.” The individual who experiences cycles of partially waking up, or tossing and turning, generally feels tired the next morning. “We’ve found – and this has been corroborated in similar studies – that reflux disease with esophageal acid exposure may account for impaired sleep in 25 to 35 percent of patients who have trouble sleeping,” Dr. DiMarino adds.

Doghramji, noting that GERD is sometimes overlooked by physicians as a source of sleep problems, offers some advice. “If an individual is getting adequate amounts of sleep but doesn’t feel refreshed during the day, consider the possibility of GERD. It’s not an innocuous problem.”

Those at risk

According to Dr. Cohen, those at risk are overweight individuals – particularly middle-aged men who have had reflux for a long time, eat fatty foods and tend to eat late at night. A high percentage of these individuals don’t experience classic heartburn all day but have problems at night. “Relaying on heartburn symptoms alone when looking for reflux and interrupted sleep will mean missing a high percentage of these patients,” he says.

Before treating a patient with sleep medications, physicians must think twice about potential reflux problems. The Jefferson study found that patients who take a sleeping pill don’t wake up as much and have fewer sleep problems. “Surprisingly,” notes Dr. Doghramji, “physicians who treat these problems need to learn to ask the questions that will make patients think about reflux disease.”

For information about treatment for GERD, or to make an appointment with a Jefferson digestive disease specialist, call 1-800-JEFF-NOW or 215-955-8900. For an appointment at the Jefferson Sleep Disorders Center, call 1-800-JEFF-NOW or 215-955-6175.
Medical Groups Keep an Eye to the Future: Flexible Work Options Create a Competitive Advantage

The ability to balance time in clinical practice with personal interests and commitments is becoming an increasingly important factor of physician job satisfaction. It is apparent that this trend will continue to shape the future of medical practice for many years to come. Medical groups will need to understand the realities of today’s workforce and find the best way to maximize the contributions of every physician – at every stage of his or her medical career.

According to the newly released 2008 Physician Retention Survey from Cejka Search and the American Medical Group Association, 48% of medical groups responding agreed that options for part-time practice encourage physicians to stay in practice while meeting personal or family needs. The challenge will be how to address staffing models so as to retain these physicians and ensure a satisfying and rewarding career, while also meeting increasing patient demands for healthcare.

Medical groups who keep an eye toward the future will recognize that they can sharpen their competitive edge in finding and keeping physicians by instituting flexible work schedules that allow work/life balance consistent with these physicians’ respective career stages. Formalized mentoring and retention programs and job satisfaction surveys that facilitate communication and feedback will also support this approach. The end result is a workplace environment that allows for both professional growth and personal satisfaction.

Greater numbers of physicians are receptive to part-time employment

Over the course of the last decade, there have been significant generational and gender shifts among physicians. As the predominantly male Baby Boomer generation approaches retirement, a younger, more diverse generation of physicians, who are likely to be female as male, are entering the workforce.

Consider these statistics:
- According to the American Medical Association, nearly half (46%) of all physicians are over the age of 50.
- The emerging generation of physicians who are 39 years of age and younger represent 28 percent of the physician workforce and are nearly equal in numbers of men and women with 55 percent male and 45 percent female.
- The Association of American Medical Colleges reports that today’s medical school enrollment is 50/50 male and female. And, even as the U.S. population grew 15 percent from 1996 through 2008, the number of doctors graduated each year remained essentially flat, at approximately 16,167 physicians annually.

- Between 2005 and 2007, the percentage of all physicians practicing part-time increased by 46% overall from 13% (5% men and 8% women) to 19% (7% men and 12% women) as reported in the 2007 Physician Retention Survey from the AMGA and Cejka Search.

Flexible work options keep physicians in practice

According to the 2008 Retention Survey, among all male physicians who leave a practice, it is those physicians who are age 55 or older who are most likely to leave the practice (30%). Among all females, those under the age of 39 are more likely to leave (46%) than their male counterparts.

When these turnover trends are combined with current physician demographic trends in today’s economic environment – it appears that there is an even greater opportunity to keep physicians in practice by offering flexible hours, particularly to pre-retirement and early-career female physicians.

Nearly two-thirds (62%) of respondents to the survey said they believe that physicians are delaying retirement due to the economy and almost half (49%) find that part-time options are enabling physicians to delay retirement. As a result, medical groups appear to be adjusting their staffing models to meet these physicians’ needs. Respondents indicated a general willingness to modify work schedules of pre-retirement physicians to encourage them to stay longer. Seventy-three percent of respondents offer their pre-retirement physicians reduced hours, 50% allow for no call responsibility and 20% allow for specialization with certain patient groups.

Alternative approaches include extended vacation periods of up to several months at a time and flexibility to modify job descriptions, as appropriate.

Today’s younger physicians – female and male – are also increasingly seeking flexible work arrangements. With more equivalent numbers of women entering the workforce, female physicians are more inclined to expect work-life balance concessions from employers, especially part-time schedules. Among those female physicians who practice less than full-time, female physicians are more likely to be part-time than their male counterparts.

Past trends sharpen the focus on retention

Organizations will need to constantly explore innovative ways to position their individual practices to focus on market realities. Physician turnover cannot be completely eliminated, but medical groups can help minimize the impact of turnover with positive efforts by leaders to appreciate the needs and expectations of their physicians.

With the expected departure of a significant number of retiring physicians and the certainty that today’s generation of physicians are focused on being content in both their work and personal life, medical groups should continue to expand and focus on developing their recruitment and retention programs.

Year to year, respondents have reinforced the effectiveness of monitoring as both a recruitment and retention strategy. A majority of member groups (65%) assign a mentor to newly recruited physicians citing that these programs help younger physicians adapt to the rigors of a demanding profession while maintaining a fulfilling personal life. Of these, nearly half (48%) offer written guidelines for their mentors.

Assigning a mentor increases retention and facilitates early identification of new physician issues and problem-solving. Job satisfaction surveys and exit interviews are another method for gaining a more complete understanding of the needs of today’s physicians. Among the member groups polled, two-thirds (66%) conduct regular satisfaction surveys of their physicians. The information gathered is used for a variety of purposes, among them being to monitor trend information (67%), create action plans (58%) and communicate to departments (52%).

One respondent cited: “We have a good handle on physician issues based on our medical director and physician evaluation program. When a resignation

Effects of the economy on part-time trends

Continued on page 11
Answering the Emerging Questions in Patient Experience

**Question 1:** Why has patient experience work become so important?

Patient experience experts are popping up in hospitals and clinics throughout the country, the latest staff hired to give more appeal to doctors and their medical care. But are such investments really necessary? After all, patients mainly seek solid medical care, and doctors and nurses are generally nice people. In my role as a consultant I have worked with experts in the emerging field of patient experience who must carefully weigh this issue every day. Here’s what they have to say about four key questions.

**Question 2:** What are some things hospitals are doing to improve the patient experience?

Experiments are underway with few proven strategies. Still, our experts find that there are a handful of key ingredients that almost always make a difference in this work.

**Effective Leadership** Peggy Kurusz, Director, Research & Development for St. Louis, Mo.-based Ascension Health says, “It’s the rare patient who can judge the clinical and technical quality of the care they receive, but everyone knows how they were treated. Emotional aspects of care drive quality for patients.”

**Question 3:** What barriers have you experienced in this work?

Ironically, many of the barriers to success are the mirror image of enablers to success, such as disengaged leadership and lack of measurement. Others are more unique and specific to this work. Overall, providers seem to think the secret is simple: generate greater involvement of patients and optimize employee experiences.

**Culture.** This is perhaps the most significant of an impact the nuances of their words and subtle actions have on patients’ and families’ perceptions of the hospital experience. Something as simple as sitting down when talking with a patient can have a positive impact.”

Employee engagement is often mentioned as key to a positive patient experience. When employees are treated with dignity and respect, they are more likely to treat their patient similarly. This strategy is far more than a ‘be nice’ directive. Staff training that includes physicians can make utterly concrete the necessary skills to produce a positive patient experience.

**Change in Traditional Hospital Culture** This is perhaps the most ambiguous quality, yet all of the experts reached out to agree that a cultural shift is necessary to improve patients’ experiences. Ascension Health refers to cultural change as “holistic, reverent care.” Hennepin County Medical Center describes the change as “relationship based care,” and the Cleveland Clinic calls it “healing solutions.” Children's Hospitals across the country were perhaps the first to recognize the impact of hospital culture on the child and the family experience during hospitalization. Family dynamics, school needs and communication are integrated into their medical care.

**Rounding Programs.** Rounding programs are clinical processes that ensure staff members check with patients at least every hour, asking if they need anything, offering to move things within reach and checking on pain status and comfort. On many units, the entire staff – from housekeeping to the hospital CEO – take turns at checking in with patients. Special training prepares staff to ask appropriate questions and offer reassurance and empathy. Hourly rounding that proactively addresses patient needs is considered a “best practice” strategy to improve the patient’s hospital experience and the hospital’s HCAHPS scores.

**Measurement:** Peggy Kurusz of Ascension Health reports that their hospitals use the “Net Promoter Score” to measure and compare the impact of programs. Establishing a measurement of current baseline patient satisfaction with their experience is a common starting point. New to health care, the Net Promoter Score asks one question: How likely are you to recommend a care provider to your family and friends? People respond using a 10-point scale. Responders are classified as “Promoters” (scores of 9 or 10), “Passives” (scores of 7 or 8) or “Detractors” (all others). A simple calculation (the percentage of Promoters minus the percentage of Detractors) yields a single number, the Net Promoter Score.

**Question 4:** What’s been discovered and what is planned?

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ABINGTON’S HUMAN MOTION INSTITUTE OFFERS NEW JOINT REPLACEMENT OPTIONS SPECIFICALLY GEARED TOWARD YOUNGER OR MORE ACTIVE ADULTS.

While traditional joint replacements continue to provide positive results for many adults, Abington has responded to the joint replacement needs of active baby boomers—and even younger patients—who want to maintain their quality of life and resume an active lifestyle.

Q: What new procedures do you offer for hip replacement?
A: The anterior hip replacement procedure is probably the most exciting new approach. It is performed while the patient is lying on his/her side, and the joint is accessed from the front with a small incision (less than half the length of a traditional incision), without the need to cut muscles or tendons.

Q: What are the benefits of the anterior hip approach?
A: Besides eliminating muscle trauma from cutting the muscle from the bone, this approach allows patients to leave the hospital faster (in two to three days) with no precautions. They return to their normal activities, including driving, in as few as two weeks. In addition, due to the nature of the procedure, the patient doesn’t have to worry about the stability of the replacement. The ideal patient for this procedure is active and maintains a healthy weight, regardless of age.

Q: Do you perform hip replacement procedures differently in young patients?
A: On some occasions, yes. There’s a procedure called surface replacement, during which, instead of drilling into the femur to secure the prosthesis, the femur head is ground down and simply capped with a prosthetic ball that is then placed back into the socket. This procedure is fairly new in the United States and offers young patients a clear advantage: if necessary they can still have a regular hip replacement later in life because the femur has not been disrupted.

Q: What recent options do you offer for knee replacements?
A: We offer surgical procedures that require smaller incisions so there is less scarring and minimal disruption to muscle, tendons and soft tissue. This minimally invasive approach can be used for partial or total knee replacements. And again, there is a quicker recovery time.

Q: What do physicians need to know about Abington’s joint replacement program?
A: We are not just committed to, but passionate about embracing new procedures and technology. We are leaders in mini-incision surgery, and perform a high volume of all types of joint surgeries. We are using computer-assisted technology. Most important, we focus on the patient. Our goal is to help our patients be as active as they want to be, within reason.

For more information, call the Human Motion Institute’s program coordinator at (215) 481-BONE (2663), or the hospital’s Physician Referral Service at (215) 481-MEDI. You may also e-mail our program coordinator at humanmotioninstitute@amh.org.
How to Sell Your Medical Practice for Millions: Create an Internal Buy-Out Fund

When you retire -- you will get virtually nothing for your practice. On the other hand, if at the outset of your practice, 10, 20, or even 30 years before you retire, you begin funding a buy-out vehicle for your practice upon retirement, and you do this properly, you are almost assured of getting a multi-million dollar check upon retirement.

Why we will see a couple of alternative techniques below, the key point is simple — buyouts of medical practice need to be planned, they need to be funded over time, and they need the commitment of the physician many years prior to the sale.

In this way, the best thing you can do to insure that you will receive millions upon your retirement for your practice, is to focus on this issue today, and implement a plan as soon as practicable.

Traditional retirement plans are likely the only ones you have heard of — qualified plans such as pensions, profit-sharing plans, 401(k)s, 403(b)s, and, for these purposes, SEP-IRAs and Keoghs. What are non-traditional plans? These are less well-known to physicians and may be called non-qualified deferred compensation plans or split-dollar plans.

We have addressed these specific plans in past articles.

As an example here, let’s consider non-qualified deferred compensation plans. These plans are relatively unknown to physicians even though most Fortune 1000 companies make them available to their executives. While many of these plans in public companies involve company stock or stock options (which, of course, do not work in a medical practice environment), many use structures that a physician certainly could easily employ in a practice.

Because they are not “qualified,” these plans can be offered only to a few employees — such as the physicians, or only partner physicians. Most importantly for this discussion, there are many ways this type of plan can create a large buy-out fund for retiring physicians, including:

A. Require each physician to put a certain dollar amount or income % into the plan. The plan’s funds then grow over a period of years and, as each older physician retires, they have a right to a certain % of the plan’s assets. Of course, this would be in addition to their qualified plan (i.e., pension) as well.

B. There could be vesting requirements built into the plan, so if physicians leave the practice they may/may not lose their benefits in the plan, allowing remaining doctors to benefit from their share.

C. While the alternatives are numerous, just by implementing a plan using A. and B., a medical practice could create a multi-million dollar buy-out fund over a 5 to 10 year period.

3. Use a Captive Insurance Company to Fund the Buyout

Captive Insurance Companies (CICs) for medical practices are typically implemented for their risk management, tax, and asset protection benefits. As described in other articles, certain small CICs can enjoy beneficial tax treatment (made even better by a 2004 law signed by President Bush), allowing the physician owners an opportunity to build tax-favored wealth, as opposed to giving profits up to insurance companies. In addition to these benefits, the CIC can be an ideal source of buy-out funds for retiring physicians.

In many cases, a CIC will have significant reserves left to invest and build each year it is in existence. Over 10-20 years, the CIC could accumulate very large amounts. If a buy-out formula is layered into the stock agreements of the CIC, this can be another source of buy-out funds for doctors when they retire from the practice as well.

Conclusion

These are just two of a number of techniques physicians can employ to “sell” their practice lucratively when they retire. As above, the key is planning.

There are no outside buyers of practices willing to pay you millions for your practice anymore. If you want such a buy-out, you must plan for it yourself.

David Mandell is an attorney, lecturer, and author of five books for physicians. Jason O’Dell is a financial consultant, lecturer and author of two books for physicians. They are both principals of the financial consulting firm O’Dell Jarvis Mandell LLC (www.ojmgroup.com) and can be reached at 800.554.7233.
Historically, it’s been a challenge to get employees to embrace their 401(k) plan. Employees frequently don’t join their 401(k) plan, contribute too little to reach their ultimate retirement goal, or select inappropriate investments for their particular situation.

Now, there’s a growing concern that 401(k) participants may overreact to the recent market downturn in ways that will have a negative long-term effect on their retirement savings. Some examples include reducing or stopping their contributions to their 401(k) plan, becoming too conservative with their investment choices, or taking hardship withdrawals or loans from their account.

Over the last twenty years, contributing to a 401(k) plan has proven to be a smart way to save for retirement. It allows the average employee to have money automatically deducted on a per-paycheck basis from their paycheck before they get a chance to spend it. The weakening economy has also reduced the amount they contribute to their 401(k) plan. Doing this not only results in less money at retirement, it prevents participants from taking advantage of a valuable investment strategy called “dollar cost averaging.”

Dollar cost averaging involves investing the same amount every paycheck, regardless of how the market is performing. Over time, this will result in more shares purchased at a lower average price because participants purchase fewer shares in an up market and more shares in a down market. By reducing or stopping the amount contributed to their 401(k) plan, participants not only miss the opportunity to buy additional discounted shares, they lose the ability to save for retirement on a pre-tax basis, a significant advantage in any market.

During market downturns, participants are also prone to seek shelter in more conservative investments, such as money market or stable value funds. These, too, are not in their best interest because they sell their original investment after the market has dropped, locking in the loss, and then are typically slow to get back into the market, preferring to see the market recover before they reinvest. In short, they’re selling low and buying high.

Simply stated, the best advice for most participants is to stay the course. Since 1980, 19.5% of the average bull market’s gains were earned in the first 10 days of the recovery from a market downturn. Because nobody is able to accurately predict when a recovery has actually started, participants should not only stay invested, they should continue to invest additional money every pay period to take advantage of the lower prices.

The weakening economy has also caused a jump in the number of employees requesting hardship withdrawals and loans from their 401(k) accounts. The consequences of taking a hardship withdrawal can be severe, including having to pay both ordinary income tax and a 10% penalty on the distribution if a participant is younger than 59½. Additionally, most plans prevent employees from making contributions for 6 months after taking a hardship withdrawal.

Loans can be tricky too. If a participant loses their job during the repayment term, the loan becomes due immediately. If the loan isn’t repaid, not only will that money not be available at retirement, but the participant will have to pay a 10% penalty and ordinary income tax on the unpaid balance. Also, loans incur double taxation because the loan is repaid with after-tax money and then the money is taxed again when it’s withdrawn in retirement.

It’s also important to note that taking a hardship withdrawal or a loan during a market downturn also involves selling at, or near, an investment’s low point. When the market eventually recovers, these assets are not in the plan to enjoy the benefit of the recovery.

How can employers help? It’s critical that plan sponsors provide their 401(k) participants with the necessary information to make informed decisions about their retirement account. Some examples include:

- Communicating the different ways investors panic during market downturns so that plan participants are less likely to overreact
- Remember, the average bear market only lasts 129 days
- Ensuring plan participants are properly allocated so market downturns have less of an effect on individual account balances
- explaining the dangers of pre-retirement distributions, such as hardship withdrawals and loans
- Adding Target Date Funds to 401(k) plans to allow plan participants to turn over control of their account to a professional money manager who will invest their retirement assets based on their expected retirement date; and
- Providing employees with access to a financial advisor to answer questions about their specific situation.

It’s the duty of retirement plan sponsors to ensure their employees don’t overreact to the recent market volatility. By providing targeted employee education, plan sponsors allow employees to place recent economic developments in their proper historical context. Remember, this too shall pass.

Neil H. Alexander is the Director of HT Corporate Services, the retirement plan consulting division of Hefren-Tillotson, Inc., an investment advisory firm headquartered in Downtown Pittsburgh. Rachel M. Hawili is a Retirement Plan Coordinator with HT Corporate Services. Reach them at 412-258-1069 or naalexander@hefren.com.

Medical Groups Keep an Eye to the Future

Rethinking staffing models offers potential for increased staff and patient satisfaction

Forward-thinking medical groups can view this challenge as an opportunity to develop effective workplace environment strategies that foster professional growth and personal satisfaction. Those who follow best practices will be rewarded with a competitive advantage: a loyal physician workforce.

Whether male or female, in early career or approaching retirement, physicians have changing needs and expectations about how to balance time in clinical practice with personal interests and commitments. The need to have work/life balance is growing in importance. The fact remains that this is an opportunity for medical groups to rethinks staffing models in order to retain experienced physicians approaching retirement and explore new ways to attract and retain younger generations of physicians.

Medical groups today are paying more attention to physician recruitment and retention efforts throughout the physician’s career cycle, including those times when options for part-time practice make sense and create continuity for delivery of healthcare. As evidenced from the Cekja Search and AMGA 2008 Physician Retention Survey, leading medical groups are committed to creatively and effectively developing practices and programs to address the challenges of physician retention — while ensuring a satisfying and rewarding career for physicians.

Lori Schatte is the President of Cekja Search.
Seminar: Is it Time for YOUR Practice to Jump on the Bandwagon?

Margolis & Company P.C., a regional CPA and business-consulting firm, will facilitate an EHR/Incentives panel discussion on Tuesday, May 12th at their offices in Bala Cynwyd, PA. Physicians News is a proud sponsor of this important seminar, which will cover the key questions that are on the minds of physicians.

Beginning in 2011, the Medicare and Medicaid programs will implement incentive payments to physicians who have adopted electronic health records (“EHRs”). Conversely, there will be penalties for physicians who do not adopt electronic records.

The incentive program announced by CMS indicates a serious attempt to promote the adoption of EHRs. Health experts say that EHRs will improve quality and reduce costs. While physician organizations such as academic faculty practice plans and large freestanding multi-specialty clinics have implemented EHRs, most small and medium-sized practices have taken a wait-and-see attitude.

The current incentive program from Medicare and Medicaid will largely underwrite the out-of-pocket costs of EHRs. It provides up to $18,000 per physician if implementation occurs in the years 2011 or 2012 plus $12,000 the second year, $8,000 for the third year, $4,000 in fourth year and $2,000 for the fifth year of use. On the other hand, practices that do not adopt electronic records will eventually see their Medicare reimbursement fall to 97% of the standard fee schedule.

In addition to providing more detail on the incentives and penalties, the EHR seminar at Margolis & Co. will explain how electronic health records can be used to improve coordination of care through information sharing across the provider spectrum.

Panelists will talk about new efficiency and quality initiatives that are likely to be tied to the use of electronic records. They will review important operational details such as the conversion from paper charts to electronic records, the efficiency and productivity gained from EHR’s and ways to streamline tasks such as prescription renewals, capturing and reporting test results, and meeting quality reporting requirements of Medicare and other payers.

Representatives from major vendors like NextGen, Sage and McKesson’s Practice Partner will be hand to explain the advantages and disadvantages of electronic health records and to provide an overview of some of the most common EHR systems. Attendees will also be given an opportunity to ask their own questions.

The seminar is on Tuesday, May 12 at Margolis & Co., 401 E. City Avenue, Suite 600 in Bala Cynwyd, PA. Breakfast at 8:30AM; panel discussion begins at 9AM. Please call (610) 784-0155 for more information. You can register for this free event via e-mail to Lisa Tierney at literney@marg.com.

Emerging Questions

Continued from page 8

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Continued from page 8

part of physicians can be especially damaging, destabilizing patient care and compromising communication. Physician’s compassion for their co-workers and their patients can have an equally positive effect. Hospitals, it seems, consequently use a “carrot and stick” approach, adopting and implementing policies to discipline disruptive behavior from physicians and others, and rewarding and recognizing those that exhibit compassionate behavior.

When it comes to increasing patient involvement, the experts surveyed perspective can be invaluable when they are ready to engage. Imagine a surgical patient assisting with the design of the pre-operative process or a recently discharged patient assisting with designing the formation of a Patient and Family Council may not occur to all providers, but can provide invaluable perspective to hospital or physician practice plans.

Interestingly enough, patients rank hospitals poorly on letting them know what is wrong with them and what to expect from testing and treatment. The patient’s care plan may be developed in a vacuum, without their input or knowledge. The mantra “nothing about me without me,” born out of the patient safety movement, can be adopted to improve the patient experience. Hospitals are wise to instill practice plans and large freestanding multi-specialty clinics have implemented EHR’s, most small and medium-sized practices have taken a wait-and-see attitude.

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Federal Stimulus Law Raises the Bar for Health Information Privacy and Security

The federal stimulus bill enacted on February 17, 2009, the “American Recovery and Reinvestment Act of 2009” (ARRA), contains many new compliance challenges for physicians and other health care entities and their vendors. In addition to creating a new federal bureaucracy for a new national electronic health records (EHR) infrastructure to set EHR standards and administer EHR stimulus money, and establishing new Medicare and Medicaid reimbursement methods to incentivize EHR adoption, ARRA contains many new health information privacy and security requirements.

This article summarizes the most significant privacy and security requirements of Title XIII of ARRA, the “Health Information Technology for Economic and Clinical Health Act” (HITECH). Under HITECH, health care providers and companies currently regulated as HIPAA covered entities will be subject to new statutory obligations, and entities which are not currently regulated under HIPAA, including vendors to health care providers, will be directly regulated under these new privacy and security obligations and will be subject to penalties for non-compliance.

New Federal Breach Notification Requirements

Prior to HITECH, health care providers had no statutory or regulatory obligations under HIPAA to notify patients of breaches of protected health information (PHI) unless required to do so by applicable state breach notification laws. HITECH not only creates a new federal breach notification obligation applicable to health care providers but also creates new breach notice obligations applicable to certain entities not currently regulated by HIPAA.

Breach notice requirements: HIPAA Covered Entities and Business Associates

No later than 60 days after discovering a breach of unsecured protected health information, a health care provider covered by HIPAA will be required to notify each affected patient that their information has been, or is reasonably believed to have been, accessed, acquired, or disclosed. Under HITECH, a breach occurs when there is an unauthorized acquisition, access, use or disclosure which compromises the security or privacy of PHI. HITECH defines “unsecured protected health information” (unsecured PHI) as protected health information that is not secured through the use of technology or methods to be specified in guidance issued by the HHS Secretary; HITECH directs the HHS Secretary to issue guidance specifying which technologies and methods render PHI unusable, unreadable or indecipherable to unauthorized individuals.

HITECH permits breach notices to be made by written or electronic mail, or by a posting on the covered entity’s web site or in a media outlet if there is insufficient contact information for 10 or more individuals. If 500 or more individuals’ information is involved, media notice must be provided and the covered entity must also immediately notify the Secretary of Health and Human Services (HHS). HITECH specifies that the content of breach notices must include a description of what happened, the dates of both the breach and the discovery of the breach, a description of the information involved in the breach, the steps that individuals should take to protect themselves from potential harm from the breach and a description of what the covered entity is doing to investigate, mitigate losses and protect against further breaches. HITECH also establishes a statutory breach notification requirement directly applicable to HIPAA business associates. Under HITECH, a HIPAA business associate is obligated to notify the covered entity of a breach of unsecured PHI. The notice from the business associate to the covered entity must be provided no later than 60 days from the discovery of the breach and must include the identification of each individual impacted by the breach.

Breach Notice Requirements: Vendors of “Personal Health Records”

Outside of the HIPAA context, vendors of personal health records (PHRs) are obligated under HITECH to provide certain notifications in the event of a breach of security. As distinct from an EHR containing PHI created and maintained by a HIPAA covered provider or health plan, a PHR is typically initiated and maintained by an individual, often through the services of a PHR vendor, such as a sponsor of an internet-based PHR platform. HITECH’s new definitions key to understanding these new PHR requirements include “personal health record”, “breach of security”, “PHR identifiable health information”, and “unsecured PHR identifiable health information.”

Under HITECH, a “personal health record” is defined as an electronic record of PHR identifiable health information about an individual that can be drawn from multiple sources and that is managed, shared and controlled by or primarily for the individual. “PHR identifiable health information” means individually identifiable health information that is provided by or on behalf of the individual and that identifies the individual or that there is a reasonable basis to believe that the information can be used to identify the individual. “Unsecured PHR identifiable health information” means PHR identifiable information that is not protected through the use of technology or methods as specified in guidance to be issued by the Secretary of HHS (through the same guidance process applicable to unsecured PHI, discussed above). “Breach of security” means, with respect to unsecured PHR identifiable health information in a PHR, acquisition of such information without the authorization of the individual.

Breach notification compliance requirements

HITECH directs the Secretary of HHS to issue regulations implementing HITECH’s breach notification requirements applicable to HIPAA covered entities and business associates and directs the FTC to issue regulations implementing the breach notification requirements applicable to vendors of PHR no later than 180 days from the enactment of ARRA. Compliance with the breach notification requirements will be expected for breaches discovered 30 days after the regulations are published.

Direct Regulation of HIPAA Business Associates

Currently, HIPAA business associates (those who perform services on behalf of HIPAA entities and in so doing access PHI, such as billing companies or TPAs) are obligated to certain HIPAA privacy and security requirements through the terms of business associate agreements with covered entities. However under HITECH, in addition to the new breach notification requirements discussed above, HIPAA business associates have other new and direct statutory obligations regarding information security and privacy. HITECH mandates that HIPAA’s obligations to implement administrative, physical and technical safeguards for electronic PHI and to implement security policies and procedures apply to HIPAA business associates in the same manner as covered entities. Additionally, the privacy and security requirements under HITECH will also apply to business associates, and HITECH directs that such privacy and security requirements be incorporated into business associate agreements with covered entities. It is significant also that HITECH mandates that HIPAA’s obligations to implement, manage and control the use of personal health records (PHRs) be enforced against HIPAA covered entities.

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**Practice Opportunities**

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Join this 750+ bed institution in one of Pennsylvania's busiest EM Departments, freed after 2,400 patients annually and serves a population of 400,000+. Employed situation, excellent salary

**GENERAL SURGERY: GASTROENTEROLOGY;оторhinolaryngology and urology - LITTLETON, NH**
Great opportunity to join the medical staff of an "award winning" hospital in Littleton, NH. Employed position, excellent salary + bonus OR work 2 years employed and Hospital will set you up on your own. Located at the Northern edge of the White Mountains and an easy drive to Boston, Montreal and Manchester. Great quality of life and affordable housing; no state income tax and the cost of living is low.

**OBSTETRICS - ST. ALBANS, VERMONT**
A wonderful opportunity to join the staff of a respected Medical Center. This is an employed position offering a competitive salary and wonderful comprehensive benefits. Call is 1:4. Located on Lake Champlain, 30 minutes from Burlington. One hour to Montreal.

**OTORHINOLARYNGOLOGIST - COASTAL NEW JERSEY**
Opportunity to be busy the first day on the job. You will find a friendly office staff with billing specialist; a surgical coordinator and 2 Audiologists. Balance Lab and labology provides additional financial opportunity (paid Hospital call). All aspects of Otolaryngology: Rhinology, Head and Neck Cancers, Voice disorders and basic ENT. Excellent comprehensive benefits; CME allowance. Partnership offered after 2 years. No buy-in. Opportunity to be part of a new Surgery Center. NY$ 60 miles north and Philadelphia about 50 miles to the west. Also enjoy sailing, golf, yachting, fishing in this family oriented community, which is host to numerous beautiful parks.

**RADIOLOGY - ST. ALBANS, VT**
Join a wonderful group of 3 Radiologists who have been set up by Northwestern Medical Center. The group is currently doing 45,000-48,000 studies per year. Northwestern Medical Center is a beautiful state-of-the-art hospital located in Northern Vermont. Attractive weekly hours with one week off every month offers a wonderful quality of life. Single office and single hospital responsibility. All of the Radiologists are set up independently but share expenses and the revenue is split evenly. Well-equipped and modern hospital with additional surgical expansion completed. New digital x-ray and outstanding community medical staff support. Low Interventional Radiology; no vascular, but Mammography requirement to do breast biopsies.

**RADIOLOGY - DIAGNOSTIC OR INTERVENTIONAL RADIOLOGIST**
Become part of a well-established Imaging Network in Providence, Rhode Island. Opportunity to teach and do research. One year to partnership for an experienced Radiologist and two years for a new grad. There is no buy-in...1 1/2 call. Located just under 45 minutes to Boston.

**UROLOGY - COASTAL NEW JERSEY**
This is a hospital-employed position. You can be set up on a net income guarantee or be employed by the Hospital...this choice is yours. The employed position offers a competitive salary and paid malpractice; excellent comprehensive benefits and CME allowance. NYC just 60 miles north and Philadelphia about 50 miles to the west. Also enjoy sailing, golf, yachting, fishing in this family oriented community, which is host to numerous beautiful parks.

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**MAMMOGRAPHY - RED BANK, NEW JERSEY**
Riverview Medical Center seeks a 2nd woman's imaging candidate for a Hospital employed position located in a year round shore community, Red Bank. 1 hour from New York and Philadelphia. Great schools! Great Beaches! Great Parks! Practice has tremendous radiology support and staff and S.O.A. technology; no call, no weekends. The Woman's Center is doubling the size of their existing facility to be completed within at the end of 2009. 100% full range Mammography position available or an 80%/20% split with other facets of woman's imaging. Very strong financial package with opportunity for part time or a full time position.

**ORTHOPEDICS - AUGusta, Geor gia**
Premier Private Practice of five seeks a general orthopedic surgeon and a foot & ankle surgeon due to future growth. Practice in 1968 and enjoys impeccable reputation, new candidate will be busy immediately. Enjoy the warm southern hospitality and home to the world famous Masters Golf Tournament. Quick track to partnership, call of 1-5 with excellent financial compensation. Located within two hours of Charleston, Savannah and Hilton Head.

**WOMAN'S IMAGING - SOUTH JERSEY**
Cooper Health System (www.cooperhealth.org) seeks a 2nd Breast Imaging physician for a full range 100% woman's imaging service. Recently named by the ACR as a center of excellence. They offer a wide spectrum of breast imaging services with active involvement with the departments of Radiation Oncology and Hematology and a progressive educational program with ongoing research. They are currently in the planning stages of opening a fourth Screening Center offering large plate digital mammography. S.O.A. technology; no call and excellent financial package including salary, bonus with a full university benefit package. Located in New Jersey, minutes from Downtown Philadelphia Candidates will have a tremendous selection of housing/living options.

**NON-INVASIVE CARDIOLOGY - HAMILTON, NEW JERSEY**
We represent a very busy hospital system owned solo practice seeking to expand their practice to meet market need. Located in Central New Jersey, this premier practice enjoys a fantastic reputation and will have a further expansion with the opening of a brand new hospital in 2 years. This full range practice has a strong outpatient and inpatient service and anticipates further growth due to the systems recent acquisition of two neurosurgeons and their entire team. They are building out a brand new stroke program and anticipate even busier immediately. Excellent financial package with full benefits. Located within thirty minutes of the world famous southern New Jersey beaches.

**ORTHOPEDIC TRAUMA SURGEON - BALTIMORE, MARYLAND**
Join as the 2nd orthopedic surgeon, employed by a 450-bed community Hospital and an academically oriented tertiary care center. Combined orthopedic and trauma practice at MIEUMS Level 1. 7 nights a month with a strong financial package. The Department of Orthopedic Surgery provides comprehensive musculoskeletal surgical care with special emphasis on reconstructive and orthopedic trauma. Outstanding facility with a great selection of communities to raise a family.

**BARIATRIC SURGEON - RANDALLSTOWN, MARYLAND**
Northwest Hospital, a 242 bed private hospital located thirty minutes west of Baltimore and is part of the LifeBridge Health system, seeks a bariatric surgeon to initiate their program in Randallstown. They are committed to creating a center of excellence and seek a surgeon to create and run their newest center of excellence and to build a premier team. The hospital enjoys a brand new, state of the art Intensive Care, Intermediate Care, and Hospice Units and is in the process of building a new Medical Office Building that will house this program. Strong financial package with opportunity to create and develop a brand new bariatric service. Great area to raise a young family with an outdoor lifestyle.

**ORTHOPEDICS - KITTANNING, PENNSYLVANIA**
Join a well respected, very busy surgeon as he expands his practice, 45 minutes north of Pittsburgh in western Pennsylvania. We seek a candidate interested in working as a solo practitioner while living in an outdoor oriented community. Great community to mix a strong practice in a great community to raise a young family. Tremendous financial and financial opportunity, with partnership available. Excellent hospital facilities with strong OR staff.

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Contact: Margie Quinlan
Phone: 800-238-7150
Email: margie@lawlorsearch.com

Contact either Margie or Richard of Lawlor and Associates for more information at 800-238-7150; fax 610-431-4092 or email them at their respective email addresses.

Visit us on the web: www.lawlorandassociates.com

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**OB/GYN**
OB/GYN - CENTRAL/SOUTHERN NJ - Excellent opportunity for BC/BE OB/GYN to join a financially sound, well established group in Southern New Jersey. Our group consists of over 50 physicians in multiple locations with numerous opportunities available for the right candidate. Practices offer full benefits, paid malpractice and access to the best practices in the area. Located at the Northern edge of the White Mountains and an easy drive to Boston, Montreal and Manchester.

**Office Space**
PERTH AMBOY, NJ - Four offices remaining for COMPATIA Health providers. Medicare approved site. Generous terms customized to your needs. 732.796.8770.

**Physiatrist**
Wanted for work in PM&R/PH/MINE practice. Multiple office locations in NJ and PA. Flexible days/hours. May do EMG/NCS, consultations and pain management if desired. Must be experienced in musculoskeletal and electrodiagnostic medicine. Must have current NJ and/or PA license. Fax CV in confidence to 609.883.7879.

**Physician Advisor / Medical Director**
PHYSICIAN ADVISOR/MEDICAL DIRECTOR: CONSHOHOCKEN, PA -- PregenyHealth, a neonatal care management company is in need of a part time pediatrician to join its growing team providing medical management and care management services. Practice provides a collegial relationship with Vascular Surgery and in full time in the future. Experience in managed care and billing required. Competitive salary and benefit package available. EOE. Interested candidates should email their CV and references to jobs@rwhm.org or fax to 856.669.6031.

**Physician Advisor/Medical Director**
PHYSICIAN ADVISOR/MEDICAL DIRECTOR: CONSHOHOCKEN, PA -- PregenyHealth, a neonatal care management company is in need of a part time pediatrician to join its growing team providing medical management and care management services. Practice provides a collegial relationship with Vascular Surgery and in full time in the future. Experience in managed care and billing required. Competitive salary and benefit package available. EOE. Interested candidates should email their CV and references to jobs@rwhm.org or fax to 856.669.6031.

**Radiology**
INTERVENTIONAL RADIOLOGIST - Radiology Group of Abington seeks a fellowship trained interventional radiologist to join our thriving 30 person practice. This is a partnership track full time position. The practice serves Abington Memorial Hospital and its outpatient centers. The group provides the full gamut of interventional services and has a collegial relationship with Vascular Surgery. There are 4 fellowship intervention radiologists who spend most of their time in intervention plus one dedicated to general.

Contact John W. Breckenridge, MD at 215.481.2087. jwbreckenridge@ahn.org.

**PRACTICES WANTED**
TWO FAMILY PRACTICES FOR SALE - More than 30 years in practice. Please contact Richard of Lawlor and Associates for more information.

**PRACTICES WANTED - Retiring physicians, part-time or full time practices.**
Call 215.669.3722.
they do. She knows that the successful listen to new ideas from credible sources and make changes that improve their lives and the lives of those that they care about... they are people of action.

Rose Ann continued, “Jennie, most of my friends just keep doing the same things that they have always done... and hope for different results. Things change when you retire, you see, and you have to change your financial strategies. That was hard for your dad to come to grips with. It’s less about rate of return and more about reliability of income. Listen… you’ve heard this many times, but listen again: I still remember sitting in that seminar many years ago and hearing facts that startled me. Those facts changed the way that I approached my financial life. The Social Security Administration reported that for every 100 sixty-five year olds, one would be very wealthy; four would be financially secure; thirty eight would be dead; and the balance would be broke. Dead broke! Think about that. That meant that only 5 percent would be financially secure at the end of every 100. The light bulb went off... don’t do what most people do… if you do, you’ll end up just like them. Find the top five percent and do what they do. They are open to new ideas; they take advice and take action to change their situations for the better... regardless of their age. That day I decided something... something very important for me... “OK, Mom, I’ve heard this before.” Jennie interrupted again.

“I chose…” Rose Ann continued as if the interruption never happened, “to be one of the five percent… to be financially secure. Your father wanted the same... but he was often stubborn, thinking he knew better. “However, as he got older... he got smarter... we don’t all. And he became more open-minded. Thank goodness... or we’d be in hot water after the market crash... just like all of our friends. We’ve done what Ted Turner and Roy Disney and other successful individuals have done. We created multiple sources of reliable income... and took full advantage of the law when it was generous and tax incentives as well. So, when the market tanked, it didn’t affect our income. We still have income that exceeds our living expenses. So we’re not happy about the crash, who is; but we aren’t up at night worrying about the impact on our lifestyle. It’s what this specialist calls recession-proof... estate planning... and when we pass, our wealth passes to you and your brothers estate tax free.”

“Well?” Jennie asked, highly skeptical.

Rose Ann paused for a minute knowing that Jennie was just like her dad when he was younger. Then Rose Ann tried to use the moment as a teaching moment. “Jennie, there was a doctor who sat next to me that night of the seminar. He said that he wasn’t even going to follow up, because he had never heard of this before. I told him that I hadn’t heard of it either, but I was willing to listen. He was not. I wonder if that doctor is more open-minded today?”

Rose Ann concluded the call “So, when you ask whether I’m panicked... well, no. We have the income we need to live as long as we live. That’s very comforting... so I don’t fret when the stock market goes up or down. I can sleep at night either way. Thanks for your concern, Jennie, but we’re fine.”

An old Chinese proverb asks, “When’s the best time to plant a tree?” Then answers, “Twenty years ago.” Then asks, “When the second best time?”

“Today. How about you? When’s the best time to recession-proof your estate plan?”

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**Federal Stimulus Law Raises the Bar for Health Information Privacy and Security (Continued from page 13)**

Currently such accounting does not have to include disclosures made for treatment, payment or health care operations covered by HIPAA. Under HITECH HIPAA-covered health care providers will be required to track and account for disclosures made through an EHR for treatment, payment and health care operations. HITECH also mandates an accounting process under which business associates will be obligated under certain circumstances to provide an accounting of disclosures of PHI.

The Secretary of HHS is to issue implementing regulations regarding the specific information that must be collected about each disclosure. The compliance timeframe for these broadened accounting requirements may be impacted by when a health care provider integrates EHRs and whether the Secretary establishes a compliance date by regulation.

**Restrictions on Selling PHI and Marketing Communications**

HITECH prohibits HIPAA-covered entities and business associates from receiving direct or indirect remuneration in exchange for any PHI, unless the HIPAA-covered-compliant authorization is obtained that includes whether the PHI may be further sold by the receiving entity. The authorization must be clear that the PHI include public health, research or treatment purposes, merger or sale of the covered entity, and service payments to business associates. Compliance with the prohibition on selling PHI is required 6 months from the issuance of implementing regulations.

HITECH also fine tunes HIPAA’s prohibitions against using PHI for marketing purposes. HITECH considers impermissible marketing to include using or disclosing PHI for communications for which the patient has not otherwise permissible authorization, such as for treatment or care management, if the HIPAA-covered provider receives payment, directly or indirectly, for the communication. However, if the communication describes a drug or biologic that is currently being prescribed, the payment to the provider is reasonable, the communication is made by the provider and the provider obtains a HIPAA-covered-compliant authorization, the communication would be permissible as part of the provider’s health care operations. Also, where the communication is made by a business associate on behalf of a covered provider and is consistent with the written agreement between the provider and the business associate, the communication would be permissible.

**Enforcement Toughened**

HITECH requires the Secretary of HHS to investigate and impose penalties where violations of HIPAA requirements are due to willful neglect. HITECH also modified the tiered levels of civil monetary penalties for violations of HIPAA privacy and security requirements, depending on levels of knowledge or willfulness, including whether violations were not known and through reasonable diligence could not be known, whether violations are due to reasonable cause, or whether violations are due to willful neglect. The amounts of civil monetary penalties attached to these tiers range from $100 to $50,000 per individual violation, subject to annual maximums ranging from $25,000 to $2 million total violations of the same requirement.

For the first time, state attorneys general may bring civil actions on behalf of state residents whose interests are threatened or adversely affected by HIPAA violations. In order to bring an action, an attorney general must give prior notice to the Secretary of HHS who has the right to intervene in the action. An attorney general may not bring an action if a federal action has already been instituted.

These enforcement provisions are effectively immediately.

**HITECH Privacy and Security: More to Come and Which to Do**

While most of HITECH’s provisions require regulatory action in order to implement HITECH’s requirements, it is also clear that new health care providers, their business associates and vendors of PHRs. As we anticipate HITECH guidance and regulations, health care providers and vendors should begin assessing HITECH’s impact, including:

• Assessing encryption or other available technology, as may eventually be blessed by HHS, in order to minimize the use of unsecured PHI and unsecured PHR identifiable health information;

• Adding breach notification processes to existing compliance programs;

• Planning a process to amend HIPAA business associate agreements to comply with HITECH’s requirements;

• For business associates who will now have direct legal obligations regarding the security and privacy of PHI, understanding and preparing to implement HIPAA’s electronic PHI security safeguards and related policy and procedures requirements;

• Reviewing existing PHI disclosure tracking and reporting capabilities to ensure that disclosures for treatment, payment and health care operations can be tracked and accounted for.

Katherine M. Keefe is the Chair, Health Law Practice at Marshall, Donnhey, Warner, Coleman & Goggin. For questions regarding HITECH or any other health information privacy and security issue, please contact Katherine M. Keefe at (610) 354-8270 or kmkeefe@mdwg.com

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**Physicians News Digest** offers an extensive catalog of online continuing medical education courses. Listed below is a sampling of current and upcoming CME offerings. For more information on these courses, and to view the entire catalog, go to PhysiciansNews.com and click on the “CME” tab.

**Optimal Prescribing**

The purpose of this course is to raise awareness and help prescribers recognize and resist persuasion of industry marketing strategies, and to enable and encourage prescribers to seek out more balanced and less biased information for prescribing decisions.

Accreditation: ACCME, ACCME Category 3 Credits™

**Reducing Cardiovascular Risk in Patients With Mixed Dyslipidemia: Effective Management of Triglycerides and Non-HDL Cholesterol**

Although progress has been made in the control of dyslipidemia for many patients, the risk for coronary heart disease universally remains elevated for those identified for treatment.

Accreditation: ACCME, ACCME Category 1 Credits™

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**CME LISTINGS**

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Fox Chase Cancer Center congratulates the long list of physicians ranked in Philadelphia magazine’s “Top Docs” issue and Castle Connolly’s America’s Top Doctors and America’s Top Doctors for Cancer. All of these nationally ranked experts are dedicated to caring for people with cancer, from diagnosis and treatment to follow-up care and survivorship programs. Fox Chase has consistently been ranked among the nation’s top cancer centers by U.S. News & World Report.