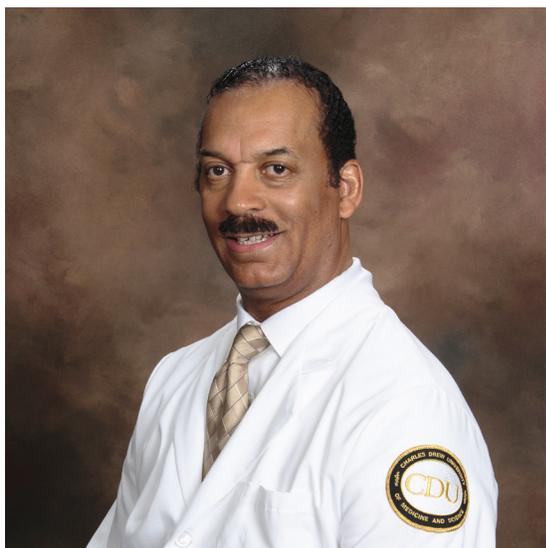




A Commitment to Serving the Underserved — and Inspiring the Next Generation

Martin Luther King Lifetime Achievement Award Winner Dr. Eleby Washington makes a difference.



Dr. Eleby Washington's orthopedic surgery career started with a surprise hip fracture.

Not his — a patient's.

"It was the first day of my internship for general surgery. It was early in the morning – I hadn't even gotten my hospital badge yet, I had no idea where I was supposed to go. Next thing I know, they're saying, 'What are you doing here? Aren't you supposed to be in surgery?'" Dr. Washington recalls.

"I had no idea I was scheduled! I ran up to the operating room as fast as I could. The chairman of the department took me through the case and allowed me to operate. I was hooked."

Dr. Washington's passion for his life's work hasn't dimmed since. "Surgery is an opportunity to make

someone's life better immediately. It's incredibly satisfying to see people who couldn't even stand pre-surgery walk into your office recovered. That's so positive. That's exactly what we're trying to accomplish."

Dr. Washington also enjoys the variety. "In orthopedic surgery, we operate on most areas of the body. One day, you're doing microsurgery on a person's finger that was cut off in an accident, the next it's doing spinal surgery on a child with scoliosis. The next it might be a hip or knee replacement."

After many successful years in private practice, Dr. Washington made a decision that changed his life and that of countless others: he went to take care of the underserved. In addition to serving as Professor and Chairman of the Department of Surgery and Orthopedic Surgery at Charles R. Drew University of Medicine and Science, Dr. Washington is the Lead Physician and Director Orthopedic Service at the

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DR. ELEBY WASHINGTON AT-A-GLANCE

Medical Specialty:	Orthopedic Surgery
Practice Location:	Los Angeles, CA
Years in Practice:	36
CAP Member Since:	2001

Martin Luther King, Jr. Outpatient Center and the Director of Orthopedic Service at Martin Luther King, Jr. Community Hospital in Los Angeles.

"We take care of people with no resources. Many are indigent, some are illegal immigrants," he explains. The challenges, Dr. Washington quickly learned, can be daunting. "It's not at all like it was when I worked in Marina del Rey. Patients are often malnourished and lack access to medications. You have to worry about homelessness, people's inability to get transportation for follow-up doctor's appointments, or inability to get physical therapy. You need to have much more understanding and empathy about whether patients can follow our instructions. In fact, we just published a paper about the challenges of achieving good outcomes with patients who have psychiatric diagnoses as well as orthopedic injuries."

Those unusual challenges require a very unusual kind of doctor. "It's hard to find doctors — especially surgeons — who will come and work in this type of environment," Dr. Washington explains.

To solve this problem, Dr. Washington is the chairman of a program at Charles R. Drew Medical School that runs pipeline programs to train the next generation

of doctors and surgeons. "We take kids in pre-school, as young as three or four years old, and start to train them in engineering, medicine, math, and sciences. We get sixth graders interested in becoming orthopedic surgeons, kids in other grades learning about what ophthalmologists or cardiologists do. Kids shadow us in the clinics and hospitals. We need to grow the next generation of doctors and surgeons right here, in this community, because their rewards will not be monetary. They have to be unafraid of the challenges of this kind of environment."

Dr. Washington has a family full of dedicated professionals. His father was an orthopedic surgeon, his son is a radiologist, his wife is an attorney for a nonprofit. One daughter is an attorney; the other is in research.

He played basketball in college and medical school, but had to give it up after he broke his ankle a few times. These days, Dr. Washington enjoys tennis. "I won't say I'm great, but it's good exercise," he says with a laugh. But his major passion is his work serving the underserved.

"You learn you have to be sensitive to more than just the surgical part of their needs," Dr. Washington observes. "A good surgeon has to have good hands, but he or she also has to have a good heart." ➦



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Risk Management — and — Patient Safety News



Two Continued Sources of Risk for Physicians: Informed Consent and Advanced Practice Professionals

by Ann Whitehead, JD, RN

The goal of CAP's Risk Management and Patient Safety Department is to prevent patient injury, prevent adverse events, and reduce claims by educating physicians to utilize risk strategies across the continuum of care. We do this by identifying the risks in our members' practices through claims analysis, hotline calls, and practice visits. This risk identification results in the creation of risk tools, forms, and guidelines that can be used by the physician in his or her office or hospital practice. Recently, our investigation revealed two continued sources of risk for our members: Informed consent/informed refusal and lack of supervision of advanced practice professionals.

Below are the steps you can follow to improve your consent process:

1. Informed consents and refusals should name the physician educating the patient. It is

recommended that the physician who completes the consent or refusal sign the form to ensure his or her confidence in the informed consent or refusal that took place. Although not required, the physician's signature, along with a witness' signature, can be the key in determining that the patient understood and signed the consent or refusal on his or her own accord. Retain a copy of the informed consent/refusal given to the patient scanned into the chart.

2. It should be completed in the practice before hospital pre-op and maintained in the patient's office record.
3. The form should list common terminology and medical terminology, specific and general risks for the procedure, alternatives to treatment, and risks of not getting any treatment.

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A second example of a current challenge for many physicians is the use of nurse practitioners and physician assistants in their practices. Supervising physicians receive claims against them when their supervised advanced practice professionals have an adverse event or a claim. Many of the problems stem from simple lack of communication. The common response to a majority of these cases is, "I didn't do anything wrong, my PA or NP didn't keep me in the loop." It is vitally important for the supervising physician to have open communication with his or her staff. By being an active component of the physician/PA or NP team, you can ensure they understand and are aware of your practice's policies and procedures.

Below are some safeguards you can implement to protect your practice:

1. When hiring a PA or NP, complete a Delegation of Services Agreement or Nursing Standardized Procedure for each practitioner. These are a written outline of what each professional can and cannot do in your practice.
2. Board requirements for supervising a PA or NP differ slightly. Get familiar with the requirements for any practitioner that is brought on board.
3. Remember, there are limits to the number of advanced practice professionals that may be supervised by one physician. Keep the ratio 1:4 in mind, one physician per four advanced practice professionals.

At CAP risk management, we are here for you. If you need advice or have questions regarding medical professional liability risk, need a form or guidelines, or would like to request a practice visit, please call the CAP Hotline at 800-252-0555 or email us at riskmanagement@CAPphysicians.com. ↩

Ann Whitehead, JD, RN, is CAP's Vice President of Risk Management and Patient Safety. Questions or comments related to this article should be directed to awhitehead@CAPphysicians.com.



Governor's Proposed Budget Big on Health Changes

by Gabriela Villanueva



We are off to a very busy legislative year in Sacramento, starting with the newly-elect governor's first state budget proposal revealed on January 10 for the 2019-2020 fiscal year.

Governor Gavin Newsom presented an ambitious agenda proposing heavy investments in healthcare, which is not surprising as he aggressively campaigned on the issue of increasing access to care. Nearly one in three dollars in the \$209 billion proposed state budget would be allocated to the state's Health and Human Services Agency.

Several noteworthy proposals are:

- **Embrace a state health insurance mandate.** While Congress eliminated the federal tax penalty for the uninsured, New Jersey, Vermont, and the District of Columbia have passed their own mandates in an effort to keep healthy enrollees from dropping coverage. The governor's proposal would include a California penalty with collected money going to subsidize health insurance (Covered California plans), building on existing federal subsidies. Massachusetts already had a state mandate before Congress' action.

- **Extend Benefits for Young Adults.** Under a law implemented in 2016, children under 19 years of age became eligible for full-scope Medi-Cal benefits regardless of immigration status. The governor is proposing to extend such benefits to eligible young adults up to age 25, also regardless of immigration status. The state would absorb 100 percent of the increased cost for the expansion.
- **Higher Tobacco Tax Usage.** The proposed budget would increase funding from the Prop. 56 tobacco tax investments by more than \$1 billion. This increased funding would go toward supplemental payments and rate increases for physicians, dentists, and other Medi-Cal funded programs.

Aside from the budget proposal, shortly after being sworn into office, Governor Newsom signed two executive orders meant to bring greater focus on health issues.

First, Governor Newsom signed an order expanding the power of the Department of Health Care Services to negotiate prescription drug pricing as a block, along with other state agencies. Harnessing the full weight of the state, California would be the nation's largest negotiator, potentially making it a model for other states. "We will use both our market power and our moral power to demand fairer prices for prescriptions drugs," Newsom said in his inauguration speech. A second executive order will create the country's first state Surgeon General.

The governor's budget proposal will now enter the legislative process, with a clearer picture anticipated with the traditional "May revise." The final budget is scheduled to be voted on and passed by June 15.

Governor Newsom's Budget Proposal can be found at:

 <http://www.ebudget.ca.gov/budget/2019-20/#/BudgetSummary> 

Gabriela Villanueva is CAP's Public Affairs Analyst. Questions or comments related to this article should be directed to gvillanueva@CAPphysicians.com.

#MeToo Movement and Its Impact on Business Owners: What You Need to Know to Protect Yourself



According to a new report on sexual harassment released by the Equal Employment Opportunity Commission (EEOC), data for fiscal year 2018 shows a more than 50 percent increase in sexual harassment lawsuits filed by the agency, and a more than 12 percent increase in the number of charges it received over fiscal year 2017. The EEOC also reported that hits on its sexual harassment web page doubled over the last year! It should come as no surprise to you that the EEOC's 2018 fiscal year coincided with the start of the #MeToo Movement.

What may come as a surprise is the fact that the average cost to defend an Employment Practices lawsuit is \$150,000, while the average cost of settlement is \$200,000. The cost to employers for an employment practices claim includes defense costs and payment of damages, and **a practice must defend itself whether or not there is merit in a lawsuit.** In fact, it can cost thousands of dollars to simply respond to an EEOC charge without any lawsuit. Employment Practices Liability Insurance (EPLI) will easily pay for itself if you are sued even once.

EPLI is insurance that protects you against employee claims alleging wrongful termination, sexual harassment, and discrimination. Most employers don't

realize that EPLI can be extended to cover claims made by third parties, such as vendors or employees at a hospital. You can also add wage and hour coverage that will protect you from employees alleging they did not get breaks, time off, or overtime pay.

The cost of an EPLI policy is a fraction of what you would pay if you end up on the losing side in a lawsuit. EPLI premiums will vary depending on a number of factors:

- Number of employees
- Amount of coverage purchased
- Whether your company has anti-discrimination and anti-harassment human resources policies in place
- Whether your company has had any EEOC complaints or lawsuits filed against it in the past

As a CAP member, you do have the Employment Practices benefit* of \$50,000 in defense costs reimbursement only, however unless you have an Employment Practices Insurance policy, your business is not covered against employee additional cost of a lawsuit and potential settlements. According to an industry study, six out of 10 non-buyers of EPLI coverage mistakenly think they are protected by other forms of insurance.

You owe it to yourself and your practice to get a quote. We at the CAP Agency stand ready to help you protect your practice. Contact us at 800-819-0061 or email us at CAPAgency@CAPphysicians.com for more information.

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Can I Really save Time and Money with CAPAdvantage?

You may have already read about CAPAdvantage, our suite of no-cost and discounted practice management programs. Leveraging the buying power of your 12,000 member-strong cooperative, all programs are administered by highly reputable, CAP-vetted vendors. But can these programs really save your practice time, money, and aggravation? Don't take our word for it. Here are a few comments from members who have taken advantage of CAPAdvantage:

- “**athenahealth** has enhanced our ability to communicate with patients as well as each other — providers and staff. It has streamlined workflows, care coordination and management, and improved documentation and billing. We can access patient information anywhere; and patient safety has improved with automated medication interaction, allergy, and dose checking.”
- “We've been using the **Patient Experience Survey Program** for months and the information has become essential to our operations. The reports helped us to target areas where we need to improve. We shared the results with our staff and we are starting to see movement in our scores.”

- “When I was just starting my OB/GYN practice in Los Angeles, I needed help with marketing my practice and building a patient base. With **PatientPop**, my practice website sees 50 percent more organic traffic and has made the front page of Google for my location and specialty.”
- “**Paylocity** has been a seamless system from the beginning. It delivers everything we were looking for in a payroll service and more. The system offers all the resources you need in order to stay compliant. The platform is very user friendly and if you need assistance, the Paylocity team is helpful and easy to work with. Altogether a fantastic platform that allows us to grow as a practice.”

Learn more about the current CAPAdvantage programs by visiting [CAPphysicians.com/CAPadvantage](https://www.capphysicians.com/CAPadvantage).

For more information, please contact **Sean O'Brien**, Vice President, Membership Programs, via phone **888-645-7237** or email CAPadvantage@CAPphysicians.com.

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Case of the Month

by Gordon Ownby



Physician Diligence Needed Even with EMR Systems

Notwithstanding the usual suspects that hinder electronic medical record implementation — initial costs, interoperability problems, training burdens, and altered physician-patient dynamics — there's also the risk of a pure system malfunction. In a malpractice suit after an admitted malfunction, a physician's actions will still be scrutinized.

Dr. PC had been the primary care physician to her 80-year-old patient for more than a decade and in the years leading up to the event, assessed her with hypotension, hypothyroidism, adrenal insufficiency, kidney disease causing anemia, Addison's Disease, bipolar affective disorder, and GERD. The patient was on a regimen of 14 different medications to manage her complicated medical conditions.

Some seven weeks following the patient's last visit, electronic records showed prescriptions ordered for her by Dr. PC. Those separate electronic prescriptions showed a lower than usual prescription for the patient's thyroid medication and a new prescription for Glipizide. Both electronic prescriptions correctly listed the patient's lengthy "other meds."

Two weeks later, the patient was admitted to the emergency room with an altered mental state. A head CT showed no pathology, but her fasting blood glucose was 22 (normal 3.9-5.5).

The patient was diagnosed with acute encephalopathy stemming from the Glipizide prescription. When the ER physician called Dr. PC about the Glipizide, Dr. PC told her that the patient was not diabetic and that she did not prescribe Glipizide. The ER physician then told Dr. PC that the

patient had a prescription bottle for Glipizide with Dr. PC listed as the prescribing MD.

After a course of electrolytes and medication over four days at the hospital, the patient spent another two weeks at a nursing facility before going home in good condition.

Following the telephone call with the ER physician, Dr. PC reviewed her patient's chart and noted for the first time that she had electronically signed an order for Glipizide. She immediately cancelled the prescription and discussed the event with her partners, who told her they had noticed instances at around the same time of patients receiving medication prescribed for other patients.

Dr. PC's medical group contacted the EMR provider, which responded with a generic message several weeks after the incident stating, "a few clients have recently reported that documents are being moved to another chart upon signing. We investigated this issue today . . . and we found this may happen to any type of document that is signed from the mailbox; i.e., the current document may be misfiled into the previous patient's chart right after being signed. Please watch for any misfiled documents in patients' charts." The letter recommended signing from an open chart as work-around pending a software update.

When Dr. PC was sued by the patient for medical malpractice, her defense attorney filed a cross-complaint against the EMR provider. The EMR system then cross-complained against Dr. PC, alleging that the Glipizide prescription was Dr. PC's own error.

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EMR Electronic Medical Record

Information

Administration Information

Medical Information

Nationality

Name

ID Card/Passport

Photo

Address

Gender

e-mail

Date of Birth

Telephone

Occupation

Marital

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Undercutting a defense that would have Dr. PC point to the EMR provider as the sole responsible party for the plaintiff's (fortunately) short-lived injuries was Dr. PC's own electronic sign-off on the actual Glipizide prescription and the lack of documentation in the patient's file regarding contacting the EMR firm.

In its cross-complaint against Dr. PC, the company mentioned only briefly the EMR's patient-tracking features and instead focused heavily on its prescription-processing functions. The company alleged that Dr. PC entered the necessary information and "clicked the requisite tabs and icons" for the software to initiate her electronic signature for the prescription. Again focusing on the prescription component of the EMR system, the company alleged there was "no bug or anomaly in the software, and that the software did not issue any prescriptions on its own accord."

The case resolved informally.

EMR systems are, in the end, human systems, and as such, physicians need to maintain all of the safeguards they would normally employ to guard against patient harm when using them. ➦

Gordon Ownby is CAP's General Counsel. Questions or comments related to "Case of the Month" should be directed to gownby@CAPphysicians.com.

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