COOPERATIVE OF AMERICAN PHYSICIANS

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PHYSICIAN Today®

Managing a Safe and Successful Practice

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An Inside Look with CAP CEO **Sarah E. Scher**

Finding Unique Solutions for Independent Physicians

AUGUST 2020

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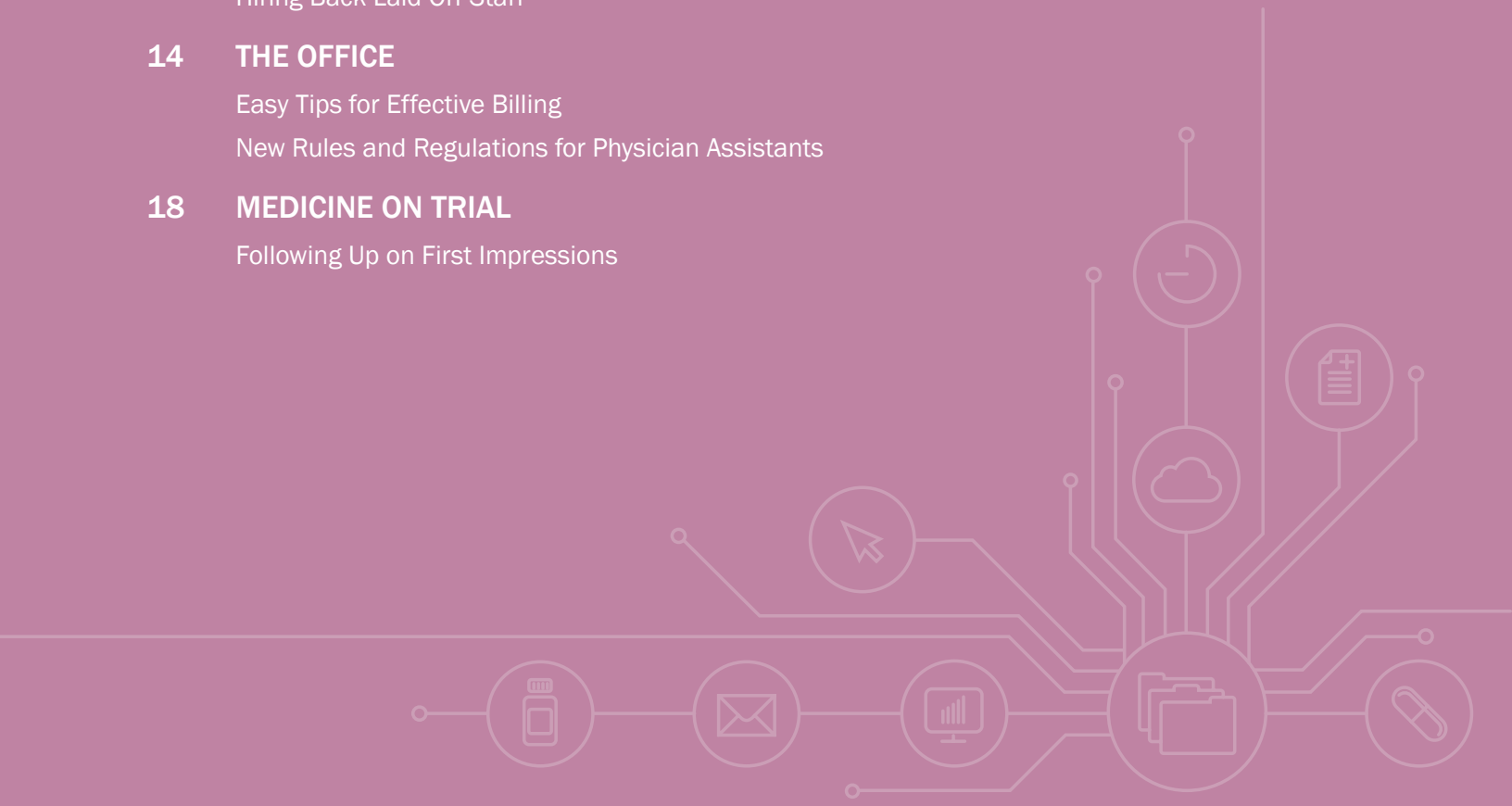

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AN INTERVIEW WITH CAP CEO SARAH E. SCHER

The Cooperative of American Physicians, Inc. (CAP) is a leading provider of medical malpractice coverage, risk management, and practice management services for California physicians. Meet Sarah E. Scher, Chief Executive Officer of CAP. Physician Today spoke with her recently to find out more about why an organization like CAP can be such a huge benefit to the state's physicians, especially now during these uncertain times.

Physician Today: Your organization is a cooperative that provides medical professional liability coverage and other services to physicians and medical practices. Why is a cooperative better for protecting and supporting physicians than an insurance company?

Sarah: The Cooperative of American Physicians was established in 1975. Our customers are members. We are uniquely positioned to be a partner in their business. In 1977, CAP formed the Mutual Protection Trust (MPT) to provide medical malpractice protection to healthcare providers. MPT today protects some 12,000 California physicians.

We do not operate with a profit motive. Our intent is to protect and bolster the success of our members' medical practices. We do not answer to investors, instead we answer to our physician members because we are physician owned and governed. Our CAP Board of Directors and MPT Board of Trustees are composed entirely of practicing physicians who recognize the unique challenges faced by healthcare providers. They hold the executive team accountable for identifying and creating solutions that permit our members to focus on patient care.

Physician Today: That sounds like a unique approach for providing coverage to physicians, but how have you been able to deliver substantial cost savings year after year?

Sarah: Unlike a traditional insurance company, MPT assesses its members for the overall amount that is anticipated necessary to pay medical malpractice claims and administrative expenses over the next 12 months. This has typically made MPT and CAP more affordable, consistent, and stable than most insurance carriers. MPT's sustained A.M. Best A+ Superior rating is proof of this.

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This year, MPT utilized its unique structure and capacity to refund assessments to members in response to the COVID-19 pandemic.

We recognized our members' need and offered not only a timely refund, but also payment deferrals, assistance with how to apply for a CARES Act loan, and risk management, practice management, and telemedicine support throughout the crisis.

Physician Today: How has COVID-19 affected your business? What are you doing to ensure your members' success during COVID-19?

Sarah: As a physician-based organization, we have a closer and more collaborative relationship with our members than a commercial insurance company might. Because of this, we were able to quickly learn, in real time, the kinds of challenges our members were facing. Some we expected, but others seemed counterintuitive. For example, we initially thought many of the practices would be overrun with sick patients. But once social distancing was broadly enacted, we learned that our members were facing massive reductions in revenue due to cancelled and delayed appointments and procedures.

That's why we quickly launched our COVID-19 Resource Center to help physicians keep up to date on the legislative and regulatory responses from state and federal officials. We are helping them manage the unique risks and patient safety challenges to stay ahead of the curve on treatment—especially relating to telemedicine and proper coding/billing—and to maximize the small business support and financing of the CARES Act.

We continue to assist members individually when they contact us for guidance. But given the scale of this crisis, we've been proactive, reaching out to our members through regular information updates and webinars to answer questions about all sorts of business issues, including closing and re-opening their offices. The CAP Risk Management, Practice Management, and Human Resources hotlines have been very busy.

And as I mentioned before, we quickly issued an assessment refund to members in April that we hope helps them, however they've been affected by the crisis.

Physician Today: What is CAP doing to help the physician community at large during the crisis?

Sarah: First, we have opened up our COVID-19 Resource Center and webinars to all physicians, medical staff, and practice managers who wish to tune in, free of charge. And the response has been tremendous. We've had hundreds of non-CAP physicians join our webinars and visit the Resource Center, because they know of our reputation for providing valuable, actionable guidance to our members.

The most common concern we are hearing from physicians is the loss in revenue caused by the shutdown and the resulting need to reduce overhead expenses. This is where CAP's time-tested business model of delivering coverage, at cost, has proven itself so valuable.

We have already helped many physicians lower their costs for malpractice coverage by switching to CAP during the crisis.

And they are saving thousands more through our enhanced services like the CAP Purchasing Alliance, a free group purchasing organization formed to help CAP members save on virtually everything they purchase for their practices.

Physician Today: How has COVID-19 affected CAP's staff members and business operations?

Sarah: In addition to attracting California's best physicians, CAP is also known for cultivating an exceptional team of staff members who continually strive for excellence in their work, much like our members do in their own practices. In less than one week, the company was able to migrate from a mostly office-based organization to a 100% work-at-home environment. CAP staff are fully engaged, productive, and accessible to our members by phone, email, and online. Having a dedicated team of seasoned professionals is one of CAP's greatest assets. It allows us to be very nimble to accommodate the rapidly evolving situation. As the progression of the COVID-19 crisis dictates, CAP will carefully plan and execute its return to an office-based environment while still maintaining a productive remote working component.

Physician Today: How is it that CAP continues to thrive here in California, while some larger, multi-state competitors face serious challenges, including downgrades of their financial ratings?

Sarah: Our commitment to California is unprecedented. Our membership continues to grow throughout the state, even as some insurance carriers shift their focus outside of California. We support county medical societies in Southern, Central, and Northern California. Our political advocacy in Sacramento and Washington, D.C., represents physicians all over California, from heavily populated coastal cities to smaller communities in the Central Valley and Northern California. We are vigilant in our constant defense of the Medical Injury Compensation Reform Act of 1975 (MICRA). CAP and Schmid & Voiles, our in-house law firm, have a strong presence across the state and have evidenced excellent results in the courtroom with a 93% success rate. The CAP and MPT California-centric business model has proven to be incredibly durable and dependable over the past 45 years.

> We will continue to leverage CAP's superior position in the marketplace in order to best serve California physicians . . . at the office, at the clinic and hospital, in Sacramento, on Capitol Hill, and especially in the courtroom.

Physician Today: All malpractice companies would like their physicians to operate safe practices in order to reduce claims. CAP seems to have achieved the right balance of providing Risk Management Services and education that actually take root. What is the formula? How do you reach your members with Risk Management?

Sarah: Our emphasis on helping physicians reduce medical risk and increase patient safety is paramount. CAP

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has built a full suite of risk management services to support the entire medical practice. Most of these services are free to CAP members and are administered by our team of experts in healthcare and law—providing a high level of personal attention and individual solutions.

Services include free onsite risk assessments, various CME programs including our comprehensive *Take Aim At Risk* course, staff risk management training programs, webinars, and popular publications like *Physician Today* magazine and the *Patient Safety Advocate*.

Members can call CAP's 24/7 risk management hotline any time to speak with a risk manager about issues such as a possible patient incident/adverse event, EHR documentation, HIPAA compliance, telemedicine protocol, patient consent, and many other topics. Our innovative CAP Cares program helps physicians follow key steps and manage a thoughtful resolution process following an adverse patient event. The CAP Cares program provides non-judgmental, confidential, and objective support, with guidance at every stage of the process—without affecting coverage rates—to help physicians avoid an actual claim by a patient.

Physician Today: How about Practice Management Support? I've heard that CAP has been expanding the types of services it provides to members.

Sarah: CAP's practice management portfolio helps members achieve successful business operations. From human resources issues—CAP HR executives provide free customized consultation to hundreds of members' medical practices every year, to billing and coding support, to regulatory and legislative education and compliance. CAP has experts, educational resources, publications, and tools that provide guidance to optimize practice success.

The *CAP Marketplace* connects physicians to essential practice services. Our *CAPAdvantage* program features more than 20 carefully vetted vendors who offer free or discounted practice-related programs, including group purchasing, payroll, credit card processing, real estate services, and practice marketing and development.

One of our newly introduced programs is called *My Practice*, a free practice management and business services program that offers members access to experienced professionals who provide advice and customized solutions to a wide variety of practice and business-related issues.

Physician Today: What other lines of coverage does CAP offer to its members?

Sarah: In 2007, CAP founded the CAP Physicians Insurance Agency to offer members the full range of competitively-priced personal and business insurance products. In addition to discounted policies and programs customized for physicians, the CAP Agency supplies CAP members with benefits in these areas at no additional cost: life and disability insurance, employment practices liability, reimbursement for legal costs stemming from various administrative actions and

employment-related lawsuits, and cyber liability protection.

Physician Today: Once we've made it to the other side of COVID-19, what can physicians and medical groups expect from the medical malpractice coverage market?

Sarah: Before this crisis began, we were already seeing a new hard market take shape:

- Rapidly increasing claim costs driven by escalating defense expenses
- Higher demands for damages from the plaintiffs' bar
- Plantiff attorney attacks on the MICRA cap on non-economic damages

While MPT has been able to maintain its A+ (Superior) Financial Strength rating from AM Best and keep costs relatively stable, many carriers have been forced to raise prices in the face of deteriorating results and adjustments to their financial ratings.

The economic, political, and social impact of COVID-19 will likely compound these challenges. We have already witnessed the dissolution of many Risk Retention Groups and recently learned of the planned demutualization and acquisition of NORCAL.

As a thriving Cooperative, CAP's primary focus is supporting our members in the delivery of safe and effective patient care. It is during a crisis such as COVID-19 where our members are called upon to go above and beyond the call of duty. CAP recognizes the challenges created by situations such as these and has underscored our partnership with our members through an assessment refund, timely resources, practice solutions, as well as prompt resolution of medical malpractice claims. We expect to continue our sterling reputation of supporting our members in the post-COVID-19 environment, and we look forward to framing solutions for a better tomorrow with our physician members.

Physician Today: We appreciate your time, Sarah. We know how busy you must be with all the recent changes happening here in California, and in the entire world.

Sarah: Thank you. It's important for California physicians to know that CAP is here working hard to help during these unprecedented times in the medical field. CAP personnel are always available to answer questions and to offer information and education. We have numerous resources to support our medical community during the COVID-19 crisis. We even have a new resource center on our website: http://www.CAPphysicians.com/articles/cap-covid-19-resource-center.

We invite any California physician to get a customized quote for affordable medical malpractice coverage at http://www.CAPphysicians.com/instant-quotePT4.

ON THE HILL

The Power of Physicians in Shaping Public Policy

Gabriela Villanueva
Government & External Affairs Specialist, CAP

When the COVID-19 health crisis subsides, the contributions by healthcare providers to lessening the suffering of the population will be one of the pandemic's major stories. But when the lessons learned in 2020 become part of necessary changes in healthcare-related laws and regulations, will physicians personally take part in that conversation?

As constituents, physicians have great influence on public policy when they bring their concerns to elected representatives and their staff. Direct constituent interactions, whether they be with local council members, school board representatives, or state or congressional representatives, can often yield greater influence on policymakers' decisions than professional lobbyists and other industry representatives. Constituents possess two major keys that hold great value: Their vote and, when strategically used, the influence of personal stories.

A 2017 study by the Congressional Management Foundation found that 79 percent of congressional staff surveyed believed that personal stories from constituents who had reached out to voice a concern or a position on a bill or issue were helpful in shaping and informing their opinions on issues. In an environment where elected representatives are constantly moving from issue to issue, it is the pause that is taken to give an issue the consideration from a real-life experience or consequence that will most strongly inform and educate the elected member. Put together a few dozen or several hundred individual voices expressing a concern and suddenly, it becomes hard to ignore.

In the sphere of public relations, there are many arms—lobbying, fundraising, donations, and campaigns—but when it comes to the true essence of our political process, the most powerful action happens in the ballot box, and that is individual power. One phone call, one fax, one email, one text, one Tweet, one Facebook posting—performed by many—becomes a roaring voice.

Here in California, we enjoy a robust political structure stemming not only from the state's 40 million residents, but also from its vast array of industries, natural resources, and even topographies. In a state as large and as layered as California, there is sure to be an office or a representative to be found for every one of those layers. As an example, 80 Assembly members and 40 state Senators want your input on issues affecting the people who put them in office. In Congress, an additional 53 House members and two Senators represent your interests. Depending on the issue, there are multiple avenues to contact these elected representatives—plus others even more local.

Contact Your Elected Representatives:

California State Representatives: http://findyourrep.legislature.ca.gov/

California Congressional Representatives: https://www.house.gov/representatives/find-your-representative

California U.S. Senators: https://www.govtrack.us/congress/members/CA

HOT BUTTON ISSUE

CAP Risk Management and Patient Safety Team

Telemedicine During the COVID-19 Pandemic

During these challenging times, the Cooperative of American Physicians, Inc. has developed the following FAQ to help physicians safely and efficiently utilize telemedicine in their practices.

What platform/vendor should I use for a telemedicine visit?

Check with your existing Electronic Health Record (EHR) vendor to see if there is telehealth functionality that can be implemented. During the pandemic, HIPAA regulations are relaxed, and providers may use whatever non-public facing communication tool they are comfortable with (Skype, FaceTime, Zoom, etc.), even if it's not HIPAA-compliant. However, if you wish to continue practicing telehealth after the state of emergency is lifted, you may want to consider investing in a HIPAA-compliant platform now. When standard HIPAA restrictions are put back into place, your practice's telehealth platform will need to be HIPAA-compliant. Using a HIPAA-compliant platform now eliminates the need to transition patients to another platform in the future.

How do I let patients know that my practice is offering this service?

The Centers for Medicare and Medicaid Services (CMS) wants practices to

continued

let patients know that telemedicine is available to allow more patients to participate. Let your patients know the practice is now offering telehealth services when they call the office. Have your office staff help support proactive patient outreach. Additionally, post announcements on your website, patient portals and other patient-facing communications.

May I see new patients via telehealth?

Medicare has relaxed the restrictions related to providing telehealth and virtual services to new patients. For the duration of the public health emergency, telehealth and virtual services can be provided to new and established patients. Patients must consent, which may be obtained before or at the time of service. Ensure that consent is documented in the patient's medical record.

How will I be reimbursed?

In the face of COVID-19, laws and commercial payor policies are quickly being amended, waived, or not enforced on both the federal and state levels to make reimbursement easier and on par with face-to-face visits. However, practices must still ensure that the documentation matches the code in which they are billing.

Reimbursement will be allowed for any telehealth covered Current Procedural Terminology (CPT) code even if unrelated to treatment of COVID-19 diagnosis, screening, or treatment.

Must I use video or is audio (telephone) sufficient?

For patients without video capability, telephone-only visits can occur; however, billing will be limited to certain codes for telephone evaluation and management (E/M) service by a physician or other qualified healthcare professional, based on time spent. Retroactive to March 1, 2020, the Centers for Medicare & Medicaid Services (CMS) is increasing payments for telephone visits to match payments for similar office and outpatient visits. According to CMS, when a clinician provides an E/M service using audio-only technology, the clinician should bill using the telephone services E/M code (99441-99443), provided that the required elements in the applicable code description are met.

Documentation should note that the visit was conducted via telephone (audio) services only. This will be important for billing, and possibly for litigation defense.

Visit **www.CAPphysicians.com/telemedicinePT4** for additional resources on incorporating telemedicine into your practice. These resources include:

- Webinar on the Proper Coding for Telemedicine Patient Visits
- Telemedicine Risk Management Strategies
- Telemedicine Patient Information Sheet
- Telemedicine Consent Forms

California Workers' Compensation Benefits and COVID-19

CAP Physicians Insurance Agency Team

Historically, communicable diseases, such as the flu, have generally not been covered by workers' compensation insurance.

On May 6, 2020, Governor Gavin Newsom signed Executive Order N-62-20.[1] In summary, the order identifies requirements to establish whether an employee who contracts COVID–19 is eligible for workers' compensation benefits. Although this particular executive order expired on July 5, 2020, the State of California is working on either extending this order or making it permanent.

Any COVID–19-related illness of an employee shall be presumed to arise out of and in the course of the employment for purposes of awarding workers' compensation benefits if all the following requirements are satisfied:

- The employee tested positive or was diagnosed with COVID-19 within 14 days after a day they performed services at the employee's place of employment at the employer's direction
- The day the employee worked at their place of employment at the employer's request was after March 19, 2020
- The employee's place of employment described above was not in the employee's home or residence
- The diagnosis of COVID–19 was done by a physician who holds a physician and surgeon license issued by the California Medical Board, and that diagnosis is confirmed by further testing within 30 days of the date of diagnosis.

This presumption is disputable and may be controverted by the employer, but unless it is controverted, the Workers' Compensation Appeals Board is bound to accept the workers' compensation claim. This presumption shall only apply to dates of injury or illness occurring through 60 days following the date of this Order, or July 6, 2020. A claim of COVID–19 related illness must be rejected by the employer and insurance carrier within 30 days after the date the claim form is filed. Employees with COVID–19 can collect temporary disability after they have exhausted all of their paid sick leave.

The California Workers' Compensation Insurance Rating Board (WCIRB) estimates such a shift could cost employers between $2.2 billion and $33.6 billion per year, with an approximate mid-range estimate of $11.2 billion, or 61 percent of the annual estimate cost of the total workers' compensation system prior to the impact of COVID–19.

If you are struggling during this time of disruption, please contact us. We will reach out to our carriers to help you with your insurance needs. You can call or email us at **800-819-0061** or **CAPAgency@CAPphysicians.com.**

[1] *www.gov.ca.gov/wp-content/uploads/2020/05/5.6.20-EO-N-62-20-text.pdf*

RISK MANAGEMENT

Patient Safety in Your Medical Practice During COVID-19

CAP Risk Management and Patient Safety Team

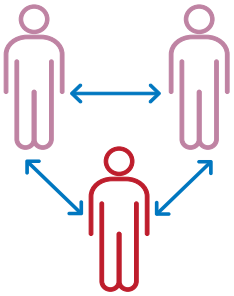
As patients resume scheduling their routine medical appointments during the COVID-19 pandemic, vigilance is required to protect them from infection and to reduce the risk of potential COVID-related litigation. The following is a sample list of risk reduction strategies to ensure your patients' safety. For more comprehensive information and risk reduction strategies on each subject, please follow the links below for resources featured on CAP's website from the California Medical Association (CMA), the American Academy of Family Practitioners (AAFP), the Medical Group Management Association (MGMA), and more.

Office Visit versus Telemedicine Visit

- Continue telemedicine encounters for routine patient visits that do not require physical examination.
- Prioritize and reserve office visits for high-risk patients, such as the elderly and those with chronic conditions, and those that require a physical exam.

Learn More: CAP's COVID-19 Resource Center, MGMA Practice Reopening Checklist

https://www.mgma.com/MGMA/media/files/pdf/MGMA-Practice-Reopening-Checklist.pdf



Physical Distancing

- Provide two separate entrances: one for well patients and the other for sick patients.
- If separate waiting rooms are not available for well and sick patients, instruct them to call your office upon arrival, and have them wait in their car or outside until it is time for their appointment.
- Have your patient bring one family member only, when necessary.
- Always keep exam room doors closed during visits.

Learn More: CMA Guidelines for Reopening

https://www.cmadocs.org/newsroom/news/view/ArticleId/48847/CMA-issues-guidelines-on-reopening-California-s-health-care-system

Infection Control

- Assess your patient via telephone the day before the appointment for symptoms of illness. Encourage a telehealth visit, when applicable.

- Require patients and their family member to wear facial masks. If they do not have one, provide them with a disposable facial mask.

- Assess patients for illness, including temperature checks, before the patient enters the building or medical office.

- Implement isolation precautions for those exhibiting signs of illness and disinfect exam room after each patient visit.

- Provide appropriate personal protective equipment to staff and require its proper use. Maintain adequate inventory as much as possible should shortages continue.

- Mandate handwashing and universal precautions.

Learn More: AAFP Office Prep Checklist, CDC Guide to Disinfecting Your Facility

https://www.capphysicians.com/sites/default/files/AAFP-COVID-19-Office-Prep-Checklist.pdf

Physician/ Staff

- Establish a temperature check and symptom monitoring policy for staff.

- If staff members become ill, encourage them to stay home. If they test positive for COVID-19, follow CDC guidelines for isolation.

- If a provider tests positive, implement steps for a potential office closure, including patient notification, and notification among high-risk patients for continuity of care, etc.

- Communicate with your staff daily and make sure everyone understands procedures.

- Call CAP's Hotline at 800-252-0555 to speak with a Risk Manager and/or Human Resources Specialist.

Learn More: OSHA Guidance on Preparing Workplaces for COVID-19

https://www.capphysicians.com/sites/default/files/OSHA3990-Guidance-on-Preparing-Workplaces.pdf

Medical experts predict that COVID-19 will have a second surge as "Safer at Home" orders and other governmental restrictions are eased. CAP recommends that you stay informed by consulting local, regional, and state governmental and health agencies; and be prepared for another possible office closure.

Dear Cappy

ADVICE COLUMN

Now Open!

Dear Cappy,

Words can't begin to describe the last few months but I'm happy to share that our medical office has been accepting patients again. What is the best way to let our patients know that we're ready when they are? How can we ensure that our patients feel confident in our risk management protocols?

Dr. Ready

Dear Dr. Ready,

First, congratulations on being proactive about establishing a plan. As patients resume scheduling their routine medical appointments during the COVID-19 pandemic, vigilance is required to protect them from infection and to reduce the risk of potential COVID-related litigation.

The goal is to communicate how your practice is ensuring the safe return of patients. Patient announcements can be shared via phone, secure email, website, social media site or patient portal.

In addition to a formal announcement, staff should also communicate the following to patients:

- Staff must wear appropriate PPE, and staff member temperatures are taken daily. Your staff may need to be limited to maintain social distancing.
- Patients must wear face coverings while in the office.
- Patient scheduling will be staggered to maintain social distancing. The office may also offer a "virtual waiting room" with patients waiting in vehicles until their appointment time.
- A COVID-19 questionnaire must be completed by every patient. If the patient shows signs of respiratory infection or fever, appropriate preventative measures will be taken.
- Hand sanitizer is offered outside of the clinic door and throughout the office for staff and patients.
- Office cleaning and sanitization procedures follow OSHA and CDC guidelines.
- Telehealth visits are available (if this is an option for your practice).

Medical experts predict that COVID-19 will have a second surge as "Safer at Home" orders and other governmental restrictions are eased. CAP recommends that you stay informed by consulting local, regional, and state governmental and health agencies; and be prepared for another possible office closure.

Cappy

Hiring Back Laid-Off Staff

Dear Cappy,

Our office was closed for a few months due to the pandemic, and we recently re-opened and have started to accept patients on a limited basis. During our closure, we had to lay off a few staff members. We expect to return to being fully staffed over the next few weeks. Can I call my recently laid-off staff members to see if they are still available? Is there anything else I need to do besides reaching out to them again?

Dr. Not an HR Expert

Dear Dr. Not an HR Expert,

If you are re-opening your practice and hiring back laid-off staff, make use of a *Return to Work* letter. The letter should outline the original date of office closure, the date the employee is expected to return to work, and the measures the practice has put in place to ensure patient and staff safety. Here is a sample template you can adapt for your practice:

[Date of Letter]

Dear Jane,

You were laid off from [Practice Name] on [Date], due to the financial impact of COVID-19.

Our patients are eager to come to the office, so we will be re-opening the office on [Re-opening Date], on a full-time basis. We have been working diligently to prepare the practice to open safely.

Here are the steps we have taken to ensure the safety of staff:

- *We have acquired necessary personal protective equipment (PPE), wipes, and disinfectants.*
- *We will be limiting patient visits to one every half hour.*
- *We will be enforcing social distancing by staying 6' apart.*
- *We will screen all employees by taking their temperature prior to the start of their shift, and we will be screening patients as well.*

We are looking forward to seeing you on [Re-opening Date]. If for some reason you are unable to return to work, please contact me so we can discuss your needs as well as the needs of the practice.

Sincerely,

If you find the need to reduce hours, your employees may be eligible for state unemployment insurance, and employers should suggest they apply for it.

Furthermore, when reducing hours or laying off staff, the employer is responsible for completing the Notice to Employee as to a Change in Relationship Form. It is also recommended that you document any action you take with an employee. Give that employee a copy of the documentation and put a copy in their file.

For free samples, please visit **https://www.CAPphysicians.com/articles/medical-practice-staffing-and-employment-during-covid-19.**

Cappy

THE OFFICE

Easy Tips for Effective Billing

Andie Tena
Director of Practice Management, CAP

Billing Patients

Any balance due that the insurance company will not pay is the responsibility of the patient. Well-documented billing statements will get paid first; unclear statements will result in patient confusion, slow or no payment, and needless re-work for your staff.

Creating Billing Statements Patients Will Pay

1. **Provide a simple account summary.** This should include what the patient has paid and what insurance has paid, with a clearly marked "Balance Due" on the first page.
2. **Design for clarity**. Research shows that bills printed on white paper, using large, easy-to-read black type get paid faster. Use bold type to emphasize items like balance due and payment date.
3. **Be ready to help**. Include clear instructions for how patients can get in touch with the practice if they have billing questions.

Make payment easy. Let patients pay online, in the office, by credit card, or by mail. The more payment options you offer, the better!

Overdue Bills

No matter how easy you make it for patients to pay, there will always be some who do not pay their bills on time. Many billing systems have templated dunning statements that can be printed on patient statements. These statements should be progressively more urgent as the overdue balance ages. For example:

"This amount is now due—please remit promptly."

"Your account is now overdue—please call our office to arrange for immediate payment."

"Your account is in danger of being referred to our collection company—please make immediate arrangements to avoid further action."

It's often effective to include a deadline, such as 10 days.

Consider setting up a "credit card on file" policy to automatically charge overdue amounts to the patient's credit card. If you do this, be sure to find a Payment Card Industry (PCI) and/or HIPAA compliant vendor. You'll also want to ensure that you have a valid authorization on file and that your patients clearly understand that automatic payment is optional.

Collection Agencies

When is the right time to refer patient accounts to a collection agency? As a rule of thumb, it is when the practice's cost to collect the debt and the net recovery are less than what would be received from a collection service after deducting applicable fees. At most practices, this is when a payment has aged 120 days or more.

If you must refer your patient's unpaid bills to a collection agency, be sure to notify the patient politely, professionally, but without apology. Recognize that sending a patient to collections is simply the next step in the process.

However, it is not a step that should be done without care or oversight. Instead, **practice staff should provide a list of patients that they believe should be referred to collections, and the physician should make the final decision.** This will help guard against mistakenly referring a professional courtesy patient to collections, or a patient that is potentially litigious.

Selecting the Right Collection Agency

Working with an outside collection agency is part of how you deliver a good patient experience. Choose an agency with a proven track record with other practices in your area, and one that reflects the attitudes and philosophies of your practice.

Some questions to ask when interviewing agencies to ensure they maintain a high standard of ethics and professionalism:

- → *How do company representatives reach out to patients?*
- → *What practices does your agency forbid when seeking collections?*
- → *Can you show us the script your staff use when they call a patient?*
- → *Can you show us an example of an early collection letter?*
- → *How will you report on collections activity to our practice? Can you show us a sample month-end report?*

If a patient calls your practice after being turned over to collections, train your staff to politely refer the patient back to the collection agency. Agencies must reciprocate this trust and responsibility by providing confirmation of all collections activity, and issuing timely month-end reports to the practice.

If your practice is large enough to merit it, consider using more than one collection agency. Comparing their results is a good way to gauge how effective each agency is at collections.

New Rules and Regulations for Physician Assistants

CAP Risk Management and Patient Safety Team

If Physician Assistants (PA)—a type of advanced practice professional—are part of your practice, then you need to know that the rules and regulations for the supervision of PAs were recently changed. Senate Bill No. 697, Physician Assistants: Practice Agreements: Supervision, was signed on October 9, 2019, and took effect on January 1, 2020.[1]

According to SB 697's sponsors, statutory limitations were overly burdensome and duplicative of other protections built into the healthcare system. SB 697 and the related Section 3500 of the Business and Professions Code references the "growing shortage and geographic maldistribution of healthcare service" and its purpose of "encourage[ing] the effective utilization of the skills of physicians and surgeons . . . by enabling them to work with qualified PAs to provide quality care." The California Medical Association stated that "SB 697 allows for more autonomy to each medical practice as to their functional relationship with their PAs." By removing the perceived burdens and duplications, SB 697 places more control in the hands of physicians and surgeons over the methods of supervision of PAs.

You are encouraged to read the entire text of SB 697, but there are several changes of note in SB 697 that may affect your practice and have risk management implications:

1. Multiple physicians and surgeons are allowed to supervise PAs, compared to the prior requirement that a single physician supervise a PA. The ratio of one physician for every four PAs remains the same.[2]

2. The PAs' medical records no longer require review by a supervising physician.

3. The supervising physicians must be available by telephone or other electronic means and no longer need to be physically available.

4. The supervision agreement for PAs will be changed from a delegation of services agreement (DSA) to a "practice agreement." Multiple physicians or an agent for the staff of the physicians or healthcare system can sign the practice agreement. DSAs in effect prior to January 1, 2020, will remain in effect.

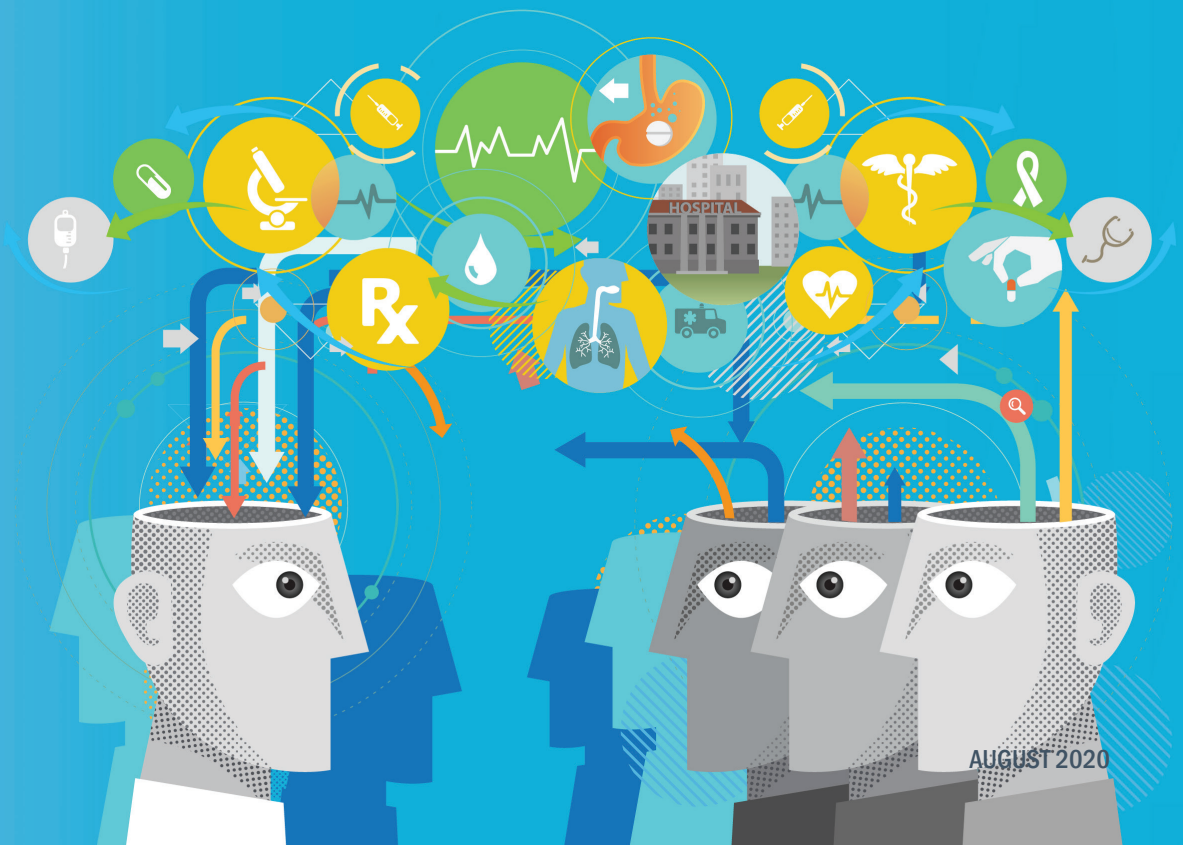
It is hard to predict how some of these changes will affect risk, claims, and liability in 2020 and beyond. For example, in the event of a claim, it is likely that plaintiff attorneys will argue that each of the signatories to the practice agreement (physicians or/and healthcare systems) are vicariously liable for the acts and omissions of the PA. Therefore, it is never too early to start the discussion, so here are a few thoughts to help you anticipate issues and put risk reduction processes and methods in advance.

The shift from single-physician supervision to multiple-physician supervision is a significant shift with new risk issues. There should still be a specific physician in charge and available at all times. You do not want a lapse because Dr. X thought Dr. Y was supervising the PA. Clear coverage processes and schedules are one way to prevent lapses.

The change from "physically available" to available by phone or electronic means, in conjunction with the elimination of the requirement for record review, creates additional risks. PAs still require supervision. In fact, a strong argument can be made that the relaxing of forms of supervision implies that other robust and specific processes, policies, and procedures, and guidelines for PAs would be indicated to prevent a decline in the quality of supervision. Moreover, the elimination of requirements for chart review and physical availability does not mean that they cannot be included in the practice agreement.

We are in a time of rapid healthcare evolution and change. It will be interesting to see how AB 697 will affect the delivery of healthcare and the related upcoming risk management changes. If you have any risk issues that arise related to PAs or any other issues, you are encouraged to contact the Physician Assistant Board of California, review the SB 697 informational bulletin[3], or consult with an attorney.

Questions or comments related to this article should be directed to riskmanagement@CAPphysicians.com.



Sources:

[1]Full text of SB 697 with analysis can be found at http://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB697.

[2]Within a general acute facility, the practice agreement must establish policies and procedures to identify the supervising physician and surgeon.

[3]Department of Consumer Affairs. Physician Assistant Board. SB 697 Information Bulletin at https://pab.ca.gov/forms_pubs/sb697faqs.pdf

MEDICINE ON TRIAL

Following Up on First Impressions

When assessing a patient, your first impression is still valid.

Gordon Ownby
General Counsel, CAP

Remember the exam-taking advice telling you to go with your first impression if no other answer seems to fit? Fast forward to your clinical practice today and that advice may still apply: At the least, be sure to follow through on your original suspicions when assessing a patient's complaints. If you don't, you've only helped a plaintiff attorney write his or her trial argument.

A 65-year-old gentleman presented to Dr. FM, a family medicine physician, with a two-week history of abdominal pain, loose stools, and diarrhea. The patient had recently been in Mexico and reported that his abdominal pain began after eating at a stateside seafood restaurant 11 days earlier. According to the patient, he felt the pain after every meal.

Dr. FM's physical exam noted the patient's abdomen as soft with diffuse tenderness, no masses, and no rebounding or significant guarding. Dr. FM's assessment was "subacute abdominal pain, etiology uncertain," and questioned possible food poisoning. Dr. FM ordered an abdominal ultrasound and lab work. The patient was advised to call if the pain worsened, or if he is unable to hold down food or liquids.

The patient had his ultrasound and lab work performed the next day. The ultrasound report noted "mild

continued

hepatomegaly," but also concluded with a finding of "minimal free fluid in the right lower quadrant with possible thickened bowel in this area. CT correlation could be helpful." The interpreting physician signed and released the report on the day of the procedure at 5:43 p.m.

The report on the lab samples collected that same day showed an elevated white blood count of 16.9 and an elevated glucose of 260. There was some evidence, however, that Dr. FM did not receive those results until they were sent to him by fax more than a week after the patient's visit.

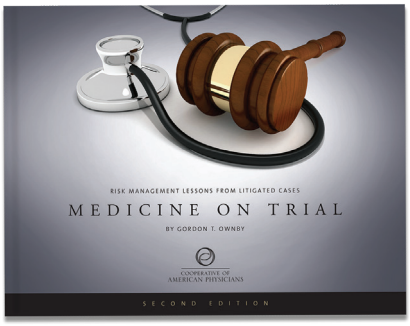
Though the patient missed an appointment scheduled for five days following the original visit, no one at Dr. FM's staff attempted to contact the patient to inquire of his condition.

Three days after that, the patient was found dead in his apartment. An autopsy noted the cause of death as "peritonitis due to ruptured bowel." A dispute asserted against Dr. FM by the gentleman's survivors was resolved prior to the initiation of an actual lawsuit.

This column has highlighted on several occasions the litigation risk when a physician fails to follow through on his or her first instincts when assessing a patient. The risk management lesson in these cases is not, of course, that a physician cannot change his or her approach to treatment. Rather, the takeaway is that when changing course, the record needs to show diligence in exploring the initial suspicion—especially in those cases where the first instinct turned out to be the correct one.

Here, the record showed that Dr. FM, by ordering the ultrasound, had decided that he would explore beyond the possibility of simple food poisoning. But though the ultrasound findings were not particularly alarming, Dr. FM's choice to not timely contact the patient with the results or follow up with a CT scan if the patient was still ill, certainly would be exploited at trial. And by waiting for a week for lab results—which did include significant WBC and glucose values—Dr. FM would be exposed to a plaintiff attorney's argument that he did not adequately follow up on his initial plan.

Again, this is not about being locked into any particular treatment plan. It is about diligently pursuing each prong of a plan to confirm an earlier suspicion or to defend a change in course.



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