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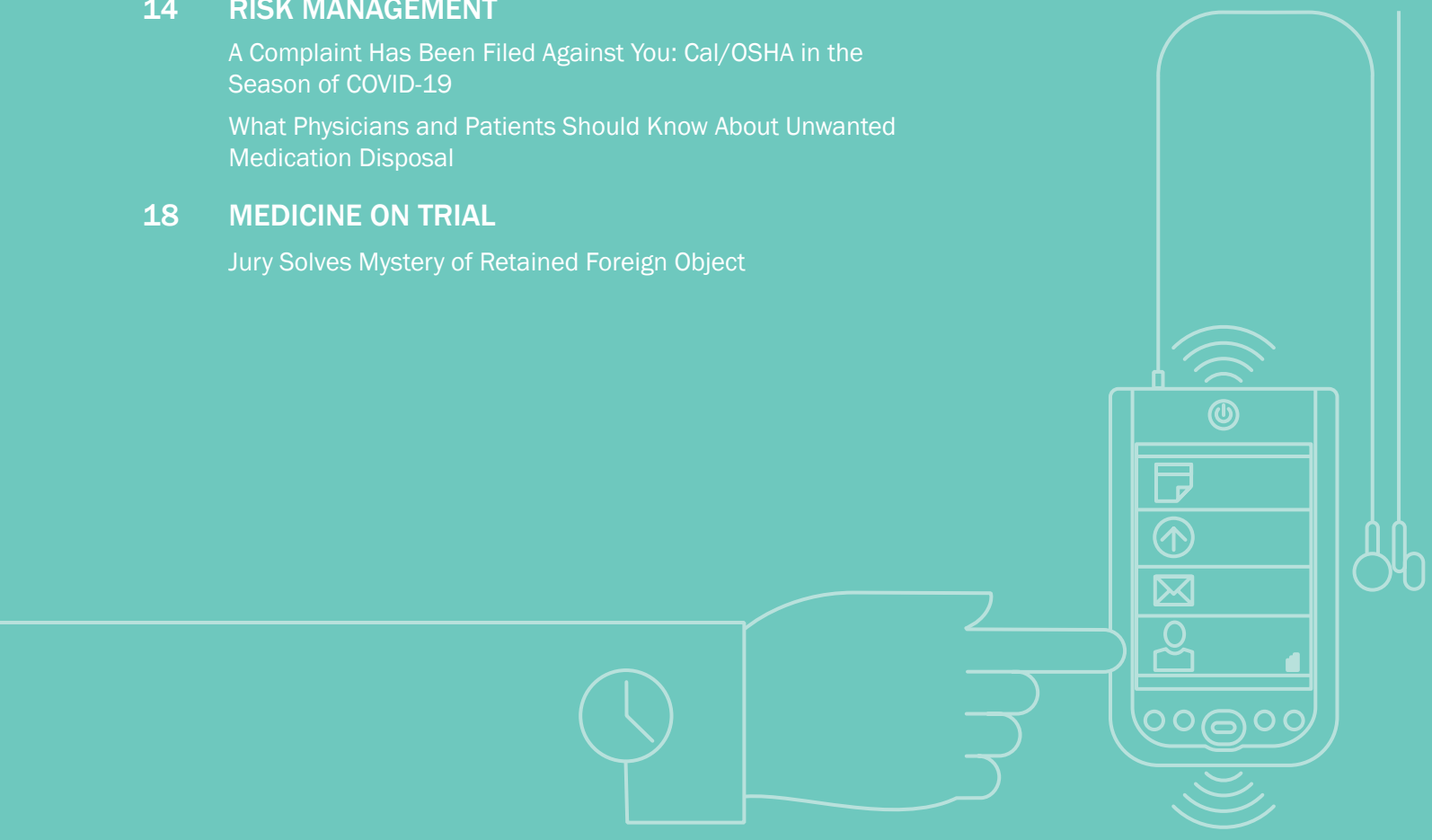


Physician Today is a publication of the Cooperative of American Physicians, Inc. The information provided in the articles and content in this publication is current as of the publication date.

A MESSAGE FROM THE CEO

When the going gets tough, the tough get going. This old saying rings truer today than ever before, especially when referring to the physicians and healthcare professionals who have braved the fight against COVID-19 in the face of hardship, loss, and adversity.

Thanks to the perseverance and resilience of our medical community, we are seeing positive advancements that may be signaling an end to the current crisis. During this critical turning point, medical practices need to be well prepared for the challenges that lay ahead, many of which have been supplemented by a whole new set of pandemic-related risks and concerns.

What may be top of mind in your practice is how you should be navigating new COVID-19 employment-related laws that impact your role as an employer. Do you have enough PPE on hand to comply with the new guidelines? Do you have written policies outlining your practice's infection control methods should Cal/OSHA pay your office a visit? Now may be a good time to review new legislation to ensure you are up to date with your protocols and procedures.

While COVID-19 has taken a tragic toll on so many in more ways than one, the impact it has had among vulnerable patient populations is truly profound. Physicians have, for a long time, taken an active interest and role in tackling implicit bias to improve healthcare disparities in their practices and communities. Despite the progress made, COVID-19 has made it evident that there is still much to be done to improve outcomes and access to quality care for our most vulnerable patients. What are you doing in your practice to combat implicit bias?

The last year has proved that safety is more important than ever and that all patients deserve the best care possible. At the Cooperative of American Physicians (CAP), these two principals have served as our hallmark for more than 40 years. As a physician-owned and governed organization, CAP always focuses on the long-standing and emerging challenges that doctors face to help them run safe and successful practices.

I hope this issue of *Physician Today* provides guidance and information on current issues to help your practice navigate the road ahead.

If you would like additional copies of *Physician Today* for your office or colleagues, or have recommendations on topics you'd like to see covered in future issues, contact us at communications@CAPphysicians.com.

We'd love to hear from you!

Sarah E. Scher, JD
Chief Executive Officer
Cooperative of American Physicians, Inc.

ON THE HILL

New California Laws in 2021

Gabriela Villanueva
Government & External Affairs Specialist, CAP

It was an interesting year in the California legislature. While the number of new laws overall was significantly reduced compared to other years, of most interest are the numerous employment-related bills signed by Governor Newsom that carry with them a strong focus on the impacts of the COVID-19 pandemic. All hope, of course, that the early promise of the new vaccines will ultimately shorten their relevance. Also included in this summary are some of the major changes affecting employers with California operations (including private practice physicians) this year.

Unless otherwise stated, all the laws discussed below took effect on January 1, 2021.

Allied Healthcare Professionals

AB 890 (Wood, D-Santa Rosa) – Scope of Practice for Nurse Practitioners

Authorizes nurse practitioners who meet certain education, experience, and certification requirements to perform, in certain settings or organizations, specified functions without standardized procedures. Requires the Board of Registered Nursing (BRN), by regulation, to define minimum standards for a nurse practitioner to transition to practice without standardized procedures. Establishes the Nurse Practitioner Advisory Committee to advise and give recommendations to the BRN on matters relating to nurse practitioners. Specifies that nurse practitioners performing certain functions without standardized procedures in listed settings are eligible to serve on medical staffs and are subject to peer review. Requires the Department of Consumer Affairs' Office of Professional Examination Services to perform an occupational analysis to assess competencies and to develop a supplemental examination for nurse practitioners, if needed, based on the assessment.

SB 1237 (Dodd, D-Napa) – Scope of Practice of Nurse-Midwives

Authorizes a certified nurse-midwife to attend cases of low-risk pregnancy, as defined, and childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning services, inter-conception care, and immediate care of the newborn, as specified and as approved by the Board of Registered Nursing. Authorizes a certified nurse-midwife to practice with a physician and surgeon under mutually agreed upon policies and protocols that delineate the parameters for consultation, collaboration, and referral, and transfer of a patient's care, as specified. Requires certified nurse-practitioners not under supervision of a physician and surgeon to provide specified disclosures and to obtain a patient's written consent. Requires the Board of Registered Nursing to appoint the Nurse-Midwifery

Advisory Committee, as specified, to make recommendations to the board.

Business

SB 1447 (Bradford, D-Los Angeles) – Small Business Income Tax Credit

For each taxable year beginning on or after January 1, 2020, and before January 1, 2021, allows a qualified small business employer, as defined, that receives a tentative credit reservation, a credit in an amount equal to $1,000 for each net increase in qualified employees, up to $100,000 for any qualified small business employer.

Confidential Information

AB 2520 (Chiu, D-San Francisco) – Access to Medical Records

Requires a healthcare provider, as specified, to provide an employee of a nonprofit legal services entity who is representing a patient, a copy of medical records that are relevant to specified public benefit programs at no charge.

AB 2655 (Gipson, D-Carson) – Invasion of Privacy: First Responders

Makes it a misdemeanor for a first responder, as defined, who responds to the scene of an accident or crime to capture the photographic image of a deceased person for any purpose other than an official law enforcement purpose or a genuine public interest. Requires an agency that employs first responders to notify those first responders of the prohibition.

COVID-19 Public Health Emergency

AB 685 (Reyes, D-San Bernardino) – Required Reporting of COVID-19 Imminent Hazard to Employees

Allows Cal/OSHA to issue Orders Prohibiting Use to shut down entire worksites, or specific worksite areas, that expose employees to an imminent hazard related to COVID-19. The law also enables Cal/OSHA to issue citations for serious violations related to COVID-19 without giving employers 15 days' notice before issuance. Employers must immediately (within one business day of the notice of potential exposure) provide written notification to all employees at a worksite of potential exposures, COVID-19-related benefits and protections, and the disinfection and safety measures that will be taken at the worksite in response to the potential exposure. In addition, employers must also notify local public health agencies of outbreaks within 48 hours of becoming aware of the "outbreak," which is defined as three or more laboratory-confirmed cases of COVID-19 among employees who live in different households within a two-week period. AB 685 sunsets on January 1, 2023.

AB 1577 (Burke, D-Inglewood) – Income Taxes as It Relates to the Federal CARES Act

For taxable years beginning on or after January 1, 2020, excludes from gross income, for state income tax purposes, any covered loan amount forgiven pursuant to the federal CARES Act and its subsequent

continued

amendments in the Paycheck Protection Program and Health Care Enhancement Act and the Paycheck Protection Program Flexibility Act of 2020.

AB 1710 (Wood, D-Santa Rosa) – Pharmacy Practice and Vaccines
Authorizes a pharmacist to independently initiate and administer any COVID-19 vaccines approved or authorized by the federal Food and Drug Administration (FDA) as specified.

AB 2537 (Rodriguez, D-Pomona) – Personal Protective Equipment: Healthcare Employees
Requires public and private employers of workers in a general acute care hospital, as defined, to maintain a stockpile of personal protective equipment, as specified, to supply those employees who provide direct patient care or provide services that directly support personal care with the personal protective equipment, as specified, and to ensure that the employees use the personal protective equipment supplied to them.

SB 275 (Pan, D-Sacramento) – Personal Protective Equipment: Employers
Requires the Department of Public Health to establish a personal protective equipment (PPE) stockpile, as specified, and requires CDPH to establish guidelines for the procurement, management, and distribution of PPE. Requires healthcare employers, as defined, to establish a PPE inventory sufficient for at least 45 days of surge consumption.

SB 1159 (Hill, D-San Mateo) – Workers' Compensation and COVID-19 Critical Workers
Defines "injury" for an employee to include illness or death resulting from the 2019 novel coronavirus disease (COVID-19) under specified circumstances, until January 1, 2023, and creates a disputable presumption, for purposes of awarding workers' compensation benefits. This presumption, as created by the Governor's executive order, was set to expire on July 5, 2020. SB 1159, however, extends this presumption beyond July 6, 2020, for firefighters, peace officers, fire and rescue coordinators, and certain kinds of healthcare and health facility workers, including in-home supportive services providers who provide services outside their own home. Employees of an employer of five or more employees are also eligible for the disputable presumption up to January 1, 2023, if their workplace has experienced an "outbreak" of COVID-19 infections.

Healthcare Plans Reimbursement

AB 2157 (Wood, D-Santa Rosa) – Healthcare Coverage: Independent Dispute Resolution Process
Makes changes to the independent dispute resolution process established by AB 72 (Bonta, 2016), which limited the ability of out-of-network physicians to bill patients for non-emergent services provided at an in-network facility and established an interim payment rate for those services. Requires the procedures established by the Department of Managed Health Care and the Department of Insurance for independent dispute resolution to include a process for each party to submit into evidence information that will be kept confidential from the other party and to specify that a *de novo* review of the claim dispute shall be conducted.

Prescribing and Dispensing

SB 852 (Pan, D-Sacramento) – Generic Prescription Drugs

Requires the California Health and Human Services Agency (CHHSA) to enter partnerships, to increase patient access to affordable drugs, including entering into partnerships to produce or distribute generic prescription drugs as specified. Subject to appropriation by the Legislature, requires CHHSA to submit a report to the Legislature on or before July 1, 2023, assessing the feasibility and advantages of directly manufacturing generic prescription drugs and selling generic prescription drugs at a fair price.

Professional Licensing

AB 2273 (Bloom, D-Santa Monica) – Special Faculty Permits: Foreign Medical Graduates

Under current law, any person who meets certain eligibility requirements may apply for a special faculty permit that authorizes the holder to practice medicine, without a physician's and surgeon's certificate, within a medical school and certain affiliated institutions. This bill authorizes the holder of a special faculty permit, a visiting fellow, and a holder of a certificate of registration to practice medicine at an academic medical center.

AB 3330 (Calderon, D-Whittier) – Department of Consumer Affairs: Regulatory Fees

Beginning April 1, 2021, increases the Controlled Substance Utilization Review and Evaluation System (CURES) fee from $6 annually to $11 and subsequently, beginning April 1, 2023, decreases the fee to $9.

Public Health

AB 2077 (Ting, D-San Francisco) – Hypodermic Needles and Syringes

Permits the sale of hypodermic needles and syringes to adults 18 years of age and older without a prescription and extends the sunset on current law authorizing a physician or pharmacist to furnish to adults, and for adults to obtain hypodermic needles and syringes for personal use without a prescription until January 1, 2026.

Reporting Requirements

AB 2821 (Nazarian, D-North Hollywood) – Richard Paul Hemann Parkinson's Disease Program

Extends, until January 1, 2022, the operation of the Richard Paul Hemann Parkinson's Disease Program, which, among other things, requires the State Department of Public Health to collect data on the incidence of Parkinson's disease in California, as specified, and requires a hospital, facility, physician, and surgeon, or other healthcare provider diagnosing or providing treatment to Parkinson's disease patients to report each case of Parkinson's disease to the department, as prescribed.

Reproductive Health

AB 2014 (Maienschein, D-San Diego) – Statue of Limitations for Medical Misconduct of Misuse of Sperm, Ova, or Embryos

Amends statute of limitations for filing a criminal complaint for crimes involving unlawful use or implantation of sperm, ova, or embryos from three years after the commission of the offense to one year after the discovery of the offense or within

continued

one year after the offense could have reasonably been discovered.

Workforce and Labor Issues

AB 1947 (Kalra, D-San Jose) – Employment Violation Complaints File Time Requirement

Extends the time that workers have to file a claim with the California Labor Commissioner for retaliation based on the exercise of workplace rights under the Labor Code from six months to 12 months from the time they believe a violation occurred and authorizes attorneys' fees for a worker who prevails on a whistleblower claim.

AB 2017 (Mullin, D-S. San Francisco) – Employee Sick Leave for Kin Care

Current law requires an employer that provides sick leave for employees to permit an employee to use at least half of the employee's accrued and available sick leave to attend to the illness of a family member ("kin care"). This bill amends the kin care law to provide that the designation of the sick leave is at the "sole discretion" of the employee. AB 2017 does not require employers to provide any additional paid time off—it simply clarifies who designates which type of sick leave is used when an employee uses a sick day.

AB 2143 (Stone, D-Santa Clara) – Settlement Agreements in Employment Disputes

Amends existing law prohibiting the use of no-rehire provisions in settlement agreements of employment-related disputes, except if the employer has made a good faith determination that the aggrieved party engaged in sexual harassment/assault, to allow an exception, permitting a no-rehire provision if the aggrieved party has engaged in criminal conduct. In order for the sexual harassment/sexual assault/criminal conduct exception to apply, an employer must have documented the conduct before the aggrieved party filed the claim against the employer. As with the prior law, no-hire agreements are permissible where there has been no claim against the employer in court, before an administrative agency, in an alternative dispute resolution forum, or through the employer's internal complaint process.

AB 2992 (Weber, D-San Diego) – Employment Practices: Leave Time

Prohibits an employer from discharging, or discriminating or retaliating against an employee who is a victim of crime or abuse for taking time off from work to obtain or attempt to obtain relief, as prescribed.

SB 1383 (Jackson, D-Santa Barbara) – California Family Rights Act: Job-Protected Family Leave

Expands the California Family Rights Act to make it an unlawful employment practice for any employer with five or more employees to refuse to grant a request by an employee to take up to 12 work weeks of unpaid protected leave during any 12-month period to bond with a new child of the employee or to care for themselves or a child, parent, parent-in-law, grandparent, grandchild, sibling, spouse, or domestic partner, as specified, and specifies that an employer who employs both parents of a child must grant leave to each employee.

HOT BUTTON ISSUE

Is Your Practice LGBTQIA+ Friendly?

Cynthia Mayhan, RN, BSN, PHN
Senior Risk Manager and Patient Safety Specialist, CAP

Have You Done an Assessment of Your Practice to Ensure There are No Implicit Biases That May Affect Your Care or Treatment Decisions?

A goal of CAP's Risk Management and Patient Safety team is to provide education to our members that will improve medical care for all patients. Addressing healthcare disparity and implicit bias now tops the list of necessary education. This article will help you understand the LGBTQIA+ patient, offer risk strategies for better care, and provide additional resources to learn more.

Despite the best efforts of most members of the medical community, disparities in healthcare delivery and outcomes for members of the LGBTQIA+ community, due to discriminatory practices, is still an issue. Fortunately, in the past decade, the Affordable Care Act (ACA), along with several important court rulings, provided protections to members of the LGBTQIA+ community by prohibiting discrimination in healthcare based on gender identity or orientation. Despite the progress made, there is still much to learn and understand in order to improve how we care for members of this vulnerable population. Here are some things to consider, along with risk reduction tips:

LGBTQIA+ Terms and Definitions

Many of us are familiar with the LBGT initialism that came into popular use in the 1990s; however, to be more inclusive of all members of the gay and transgender community, it has now evolved to LGBTQIA+, but many who are not a part of this community are left wondering, what does this mean? LGBTQIA+ stands for lesbian, gay, bisexual, transgender, queer, intersex, asexual, and other sexual and gender minorities. By becoming familiar with and trying to understand some of the terms used by the LGBTQIA+ community, this not only demonstrates to your patients that you have taken an interest in learning more, but will also enable you to better understand what some of your patients' individual needs may be. Here is a sample of some recognized terms:

Sexual Orientation - how a person describes his or her emotional, romantic, or sexual attraction to others. i.e., lesbian, gay, bisexual, etc.

Gender Identity - an individual's concept of his or her maleness, femaleness, a combination of both, or neither.

Transgender - a person whose gender identity differs from the sex assigned biologically at birth. For example, a trans-

continued

woman is one who was born a biological male, but now identifies a female.

Non-Binary - refers to an individual that does not fit into another LGBTQIA+ classification.

More terms and their definitions can be found here: **https://www.lgbthealtheducation.org/publication/lgbtqia-glossary-of-terms-for-health-care-teams/**

As you become familiar with the terms, keep in mind that their use may vary across LGBTQIA+ sub-communities, so it is best practice to defer to the terms your patient prefers.

Considerations for the LGBTQIA+ Patient/Things to Consider/Risk Strategies

Names: Patients who identify as non-binary may have two names—their legal name and a chosen name that they selected. It is best practice to obtain both and use the chosen name when addressing your patient.

Pronouns: Pronouns used in EHR auto-generated letters (EOBs, follow ups, reminders, etc.) are populated with sex-assigned at birth as noted in the medical record, so the problem is that transgender and non-binary patients will have the wrong pronoun in their letters. The solution is to incorporate gender-neutral pronouns. Terms such as "they," "them," and "theirs" when used as singular pronouns are now considered to be grammatically correct by most major dictionaries and, in fact, have already been adopted by some corporations and major U.S. newspapers.

Radiological Testing and Transgender Males: Transgender males who have not undergone gender confirmation surgery (GCS) may still have female reproductive organs, so it is appropriate to screen for pregnancy and to explain why it is necessary to ask.

Gender Identity Care: Primary care providers need to be prepared to refer their patients who are seeking to start hormone therapy for gender confirmation. The referral could be to an endocrinologist or a reproductive endocrinologist; however, it is never okay to refuse to assist a patient based on the provider's feelings about gender confirmation.

Surgery Concern for Transgender Women: Transgender women taking estrogen may not be aware that it is a thrombogenic; however, pre-operatively, this needs to be addressed. In most cases, the surgeon will want the patient to temporarily discontinue taking it, but it is very unlikely the patient would be willing. In this case, the best approach is to discuss the risks with the patient and if they decline to stop it, then document the informed consent discussion and have them sign an informed refusal form.

Surgery Concern for Transgender Males: Female airways are smaller than their male counterparts, so when selecting an endotracheal tube for a transgender male, the tube selected should be the appropriate size for a biological woman.

Transgender Women: Pre-Exposure Prophylaxis (PrEP) should be offered to all biological male (i.e., transgender women) patients who are at risk for exposure to HIV.

Disease Screening: When screening for conditions (endometriosis, autoimmune diseases, etc.) or cancers (cervical, ovarian, prostate, etc.) that are limited to, or more prevalent with, one gender, remember to screen with consideration to the patient's gender assigned at birth.

In healthcare, we continually strive to do better for our patients and by being open to discussing sensitive topics and asking direct questions about sexual preference and identity, the provider can gain a better understanding of the patient's needs. This not only enables them to provide better, safer care, but reassures the patient that that he or she is understood and accepted, which in turn helps improve patient compliance and satisfaction.

For more information about Implicit Biases visit here: https://www.lgbtqiahealtheducation.org/wp-content/uploads/2018/10/Implicit-Bias-Guide-2018_Final.pdf

Implicit bias self-assessment quiz:

https://implicit.harvard.edu/implicit/takeatest.html

Information and resources from the AMA:

https://www.ama-assn.org/delivering-care/population-care/understanding-lgbtq-health-issues

Telemedicine Webside Manner: Putting Your Best Face Forward

Amy McLain, BSN, RN
Vice President, Risk Management & Patient Safety, CAP

This past October, Dr. Neel Naik, the Director of Emergency Medicine Simulation Education and an Assistant Professor of Clinical Emergency Medicine at Weill Cornell Medicine in New York City, spoke at the American Society for Health Care Risk Management's (ASHRM) virtual annual conference. In his presentation on telemedicine, he made several interesting points:

1. Physicians do not understand how to engage with the patient
2. Physicians do not know how to present themselves to patients
3. Physicians do not know how to conduct a virtual physical exam

Dr. Naik went on to say that "physicians must alter their 'bedside manner' from traditional in-person care to better accommodate patient needs during video-based telehealth visits." Yet, this important skill is often not taught.

If this is the case, then many physicians must be struggling to conduct a telemedicine visit with their patients and may be at increased risk for patient complaints to insurance companies and/or the medical board. It's also important to know that telemedicine is a form of healthcare delivery and the standard of medical care provided to patients is the same whether you see them in person or not. Therefore, if an appropriate exam is not performed during a telemedicine visit, claims may arise from misdiagnosis and treatment errors.

To ensure your patients have an optimal virtual experience and best possible medical outcomes from their next telemedicine appointment with you, CAP recommends the following tips:

- **Prepare:** You want your patient to have the utmost confidence in you. Know in advance why your patient is scheduled. Read the chart before your video encounter. Have a plan of action.
- **Time:** Don't be in a rush. Your patient will feel unimportant and you're likely to miss important clinical details. Schedule the appropriate amount of time for each patient. Allow time for questions and be aware of "the doorknob phenomenon," when a patient waits until the physician is leaving before asking a critical question.
- **Location:** Follow privacy and confidentiality rules. Choose a quiet, private location with a neutral professional background. Remove distracting or inappropriate items. Encourage your patients to find areas in their homes to interact privately with you.
- **Technology:** Ensure that your technology works correctly. You don't want to delay or cancel your patient's appointment because

your system is not functioning properly. Check your camera, your computer, your microphone, your speakers, and your internet connection. Then, check it again. Use healthcare-specific or end-to-end encryption platforms. Have IT on speed dial.

- **Lighting:** Poor lighting conditions have an enormous effect on video quality. You want to look your best and allow your patient to see your face clearly. Use natural lighting. Face the window—never sit with your back to a window. If you do not have a window, find a soft light to put in front of you.

- **Camera:** Avoid unflattering and awkward angles by framing the camera correctly. Place the webcam at eye-level and position yourself so that you are in the center of the patient's screen. Avoid embarrassing situations. Remember, the camera may still be on.

- **Sound:** Most microphones pick up background noises that can be annoying or distracting. Use quality headphones/earbuds to improve hearing. Mute yourself when your patient speaks. Recognize that there is generally a slight delay between the time words are spoken and when they are received. Avoid talking over your patient. Caution: hot mics!

- **Appearance:** Present yourself as if you were in the office exam room with your patient. Introduce yourself and your role. Wear your white coat and badge or medical professional attire. Be mindful of your body language. Avoid distracting behaviors, such as excessive gesturing with your hands and distracting facial expressions.

- **Engage:** Confirm your patient's identity. Smile. Pay close attention to your patient and actively listen. Participate completely as if you were physically in the same room. Minimize distractions and avoid disruption, such as email/message notifications or phone calls. Look into the camera to maintain good eye contact. If you need to look away to take notes or consult a resource, tell them so they don't think you are doing other work.

- **Collaborate:** Guide your patient through the visit. Have the patient adjust lighting and camera, if needed, for closer inspection. Demonstrate and coach your patients to assist you with their physical examinations. Have them use their thermometers, blood pressure cuffs, and other medical tools to gather additional clinical data.

- **Close the Loop:** Document the telemedicine visit in the medical record. Send a visit summary along with written next-step instructions to the patient.

Resources:

For more in-depth information about telemedicine and webside manner, please visit these websites:

www.CAPphysicians.com

California Medical Association (CMA)
www.cmadocs.org

American Medical Association (AMA)
www.ama-assn.org

Medical Group Management Association (MGMA)
www.mgma.org

Dear Cappy
ADVICE COLUMN

Cyber Attackers: Prevent or Pay Up?

Dear Cappy,

I have a colleague who had to pay a hefty ransom after a cyber attacker encrypted all of the practice's files, including patient records, financial data, and other information. I did not think this was a big issue for smaller practices. How can I avoid a cyber attack in my practice?

Dr. IT Friendly

Dear Dr. IT Friendly,

Unfortunately in this day and age, cyber attacks are commonplace, especially among healthcare organizations where attackers can gain access to confidential patient records with highly sensitive data. Hackers can easily install dangerous ransomware into your network and hold all of your files and data hostage unless payment is received.

Here's how to protect your practice:

Backups

Backups are an effective strategy to reduce ransomware damages and business disruption.

Use the 3-2-1 backup rule:

- Create 3 copies of your data
- 2 on different media types
- 1 copy isolated offsite

All backups (even cloud drives) should be segregated or isolated from your operating network to protect them from being infected by malware as it spreads through your operating network. Strong access controls can mitigate the risk of compromise.

Always Update Your Software

Make sure your organization has a patch management policy ensuring patches and updates are tested thoroughly and rolled out organization-wide, preferably automatically. Patch management is the timely deployment of security patches designed to address vulnerabilities or mitigate the risk.

Train Your Employees

"Phishing" emails are a common ransomware deployment method. Maintaining a culture of security and phishing awareness is one of the most important action items you can take to protect your company. Employees should be properly trained and should never click on an attachment or a link in an email from an unverified sender.

Cappy

Are Your Lease Negotiation Skills Sharp enough?

Dear Cappy,

The lease for my medical office space is set to expire. Should I try to renegotiate my lease with my landlord? I don't know where to start.

Dr. Just Lease It

Dear Dr. Just Lease It,

To answer this question, we asked a dedicated physician consultant from Bailes & Associates. Before you renegotiate your current lease, here are steps to consider:

- Consider a financial analysis to determine your wants and needs. Some things to consider are the size of your suite, your minimum and maximum of the new base rent, your desired maximum term, the cost of your parking requirements, and so on.
- Conduct a market analysis to determine the area's market rents and the availability of space in the target area. Determine what the landlord's concessions are.
- Tour several comparable sites to determine the pluses and minuses of each.
- Analyze and compare the findings of the strategic planning, market analysis, financial analysis, and the site tours.
- Propose your terms and concessions to the landlord's leasing agent, based on item four. Then prepare for the landlord's rejection or his or her counter proposal, which starts the negotiation phase.

Cappy

Bailes & Associates Commercial Real Estate Support

Bailes & Associates, Inc. helps physicians secure new or additional office space and can help effectively negotiate lease renewals. If you are interested in more information, please call Gary Pepp at 562-743-1695 or email gpepp@bailesre.com.

Bailes & Associates is part of CAP's suite of business and practice management programs. CAP members receive no-cost, no-obligation real estate support.

Bailes & Associates, Inc. License No. 00831364 Gary Pepp; License No. 00925108

Risk Management

A Complaint Has Been Filed Against You: Cal/OSHA in the Season of COVID-19

Lee McMullin
Senior Risk Management & Patient Safety Specialist, CAP

It's no surprise that COVID-19 caught the personal protective equipment (PPE) storehouses in short supply. In turn, the supply versus demand issues have generated complaints from healthcare workers in acute care settings about the lack of PPE and the real or perceived risk of COVID-19 exposure. Many of these complaints are directed to the regulatory body that enforces the state's mandated illness, injury, and aerosol transmittable diseases prevention programs, commonly known as Cal/OSHA—technically, the Department of Industrial Relations, Division of Occupational Safety and Health.

As the private sector reopens, employees in medical office settings are making similar complaints as their hospital counterparts, which can generate a Cal/OSHA complaint letter to the business (your medical practice). Failure to respond results in an unscheduled inspection of your workplace and can result in fines if violations are found.

A copy of the Cal/OSHA complaint must be posted in a prominent location for three working days, or until the hazard complained about (if true) is corrected—so all the staff know about it. The rules allow for anonymous complaints.

Most of the complaints are "the employer is not providing PPE for COVID-19." So, what are these rules and what must you do to comply?

In short, you'll find these rules in the California Code of Regulations under Title 8, which has more words than a small town's phone book. While the total depth of that rule is beyond the scope of this commentary, you need to know that at its core insofar as COVID-19 is concerned, it's all about PPE and infection control. It's the stuff you're already doing, but have you written it down in case Cal/OSHA wants to pay you a visit? For example—do you have a written policy addressing:

- Training of all employees on the use of PPE provided by the employer
- A log of all PPE training
- Mandated use of PPE in all clinical areas
- Use of PPE in non-clinical areas, except when at a personal workstation, and during meals and breaks, provided the employee maintains a six foot or greater distance from others
- Mandatory use of masks when entering and exiting the building
- Disinfection of clinical and non-clinical areas, work surfaces, and frequent contact points, i.e., doorknobs
- Other practices specific to your office like thermal scanning, having patients wait outside to limit the number in the reception area, etc.

A log of work related illnesses—such as if a staff member tests COVID positive and claims to have contracted it at work—referred to as Form 300. You can find it at **https://www.dir.ca.gov/dosh/doshreg/apndxa300final.pdf**

Electronic submission of workplace injury/illness records annually—more on that at **https://www.dir.ca.gov/dosh/calosha-updates/log300-reporting.html**

Periodic monitoring of CDC recommendations on PPE and healthcare worker exposures. The most recent bulletin is at **https://www.cdc.gov/coronavirus/2019-ncov/hcp/guidance-risk-assesment-hcp.html**

Guidance on Preparing Workplaces for COVID-19, OSHA 3990-03 2020 is at **https://www.osha.gov/sites/default/files/publications/OSHA3990.pdf**

What Physicians and Patients Should Know About Unwanted Medication Disposal

Kimberly Danebrock, JD, RN, CPPS
Director of Risk Management, CAPAssurance
Director of Risk Assessment Peer Review, MPT

Most physicians would likely not be surprised that many American homes have an accumulation of unused, unwanted, or expired medications. But did you ever consider the potential safety hazards these surplus medications present?

It's not uncommon for patients to take their unwanted medication and, with good intentions, give it to a family member or friend complaining of similar symptoms who has not yet seen a physician and failed to be evaluated. Controlled substances pose additional safety hazards. While young exploring children may take them accidentally, teens and adults may take them to experiment—creating potential or continued drug abuse behavior. In fact, many instances of misused opioids in the United States are the result of leftover medications obtained by family and friends.

Occasionally, believing they are being diligent, physicians with patients complaining that an opioid has an intolerable side-effect or is not working, will have the patient bring the unused medication back into the office before a new prescription is provided. As the physician, you might believe it safer for the patient and your license if you were to ensure the safe disposal of any unused controlled substances. However, according to the DEA, physician offices do not qualify as those authorized to collect medications and it is NOT advisable for physicians or office staff to accept, take back, or dispose of any unused, unwanted, or expired medications.

The reality is that patients and physicians alike often do not know how to properly dispose of unwanted medications.

To avoid diversion and decrease the potential abuse of prescription medications, the DEA began take-back programs. These consist of designated drop boxes where patients can anonymously turn in unwanted prescription medications—no questions asked. However, since these national and local events are typically held only a couple of times a year, it is also recommended to check with local pharmacies and Sheriff's Departments for regular positioned prescription drop box locations in your area.

Since only DEA-designated officials can receive and dispose of controlled substances, the best way you can assist your patients is to learn local take-back information and educate your patients on the importance of proper disposal of unwanted medications. Some risk strategies you may wish to employ:

01

Download a copy of *A Patient Guide to Disposing of Unused, Unwanted, or Expired Medications* at **https://www.capphysicians.com/sites/default/files/Patient-Guide-Disposing-Medications.pdf** for tips on properly disposing of medications including take-back programs, pharmacies, Sheriff's Departments, and, as a last resort, how to properly dispose of medications at home.

02

Download a copy of *A Patient Guide to Disposing of Unused, Unwanted, or Expired Medications* at **https://www.capphysicians.com/sites/default/files/Patient-Guide-Disposing-Medications.pdf** and share it with those patients that would benefit from the education.

03

Prescribe small amounts (few pills) of opioids until it is determined the patient can tolerate the medication. This prevents the patient from having extra pain medications at home and from potential misuse by the patient and/or family members.

04

Do not dispose of controlled substances that your patients bring into the office. Instead, provide patients the proper local disposal sites information and instructions.

05

If there are no local take-back programs in your area and you work in an area with multiple physician offices, consider coordinating with physician offices/buildings and local law enforcement to organize a local take-back day.

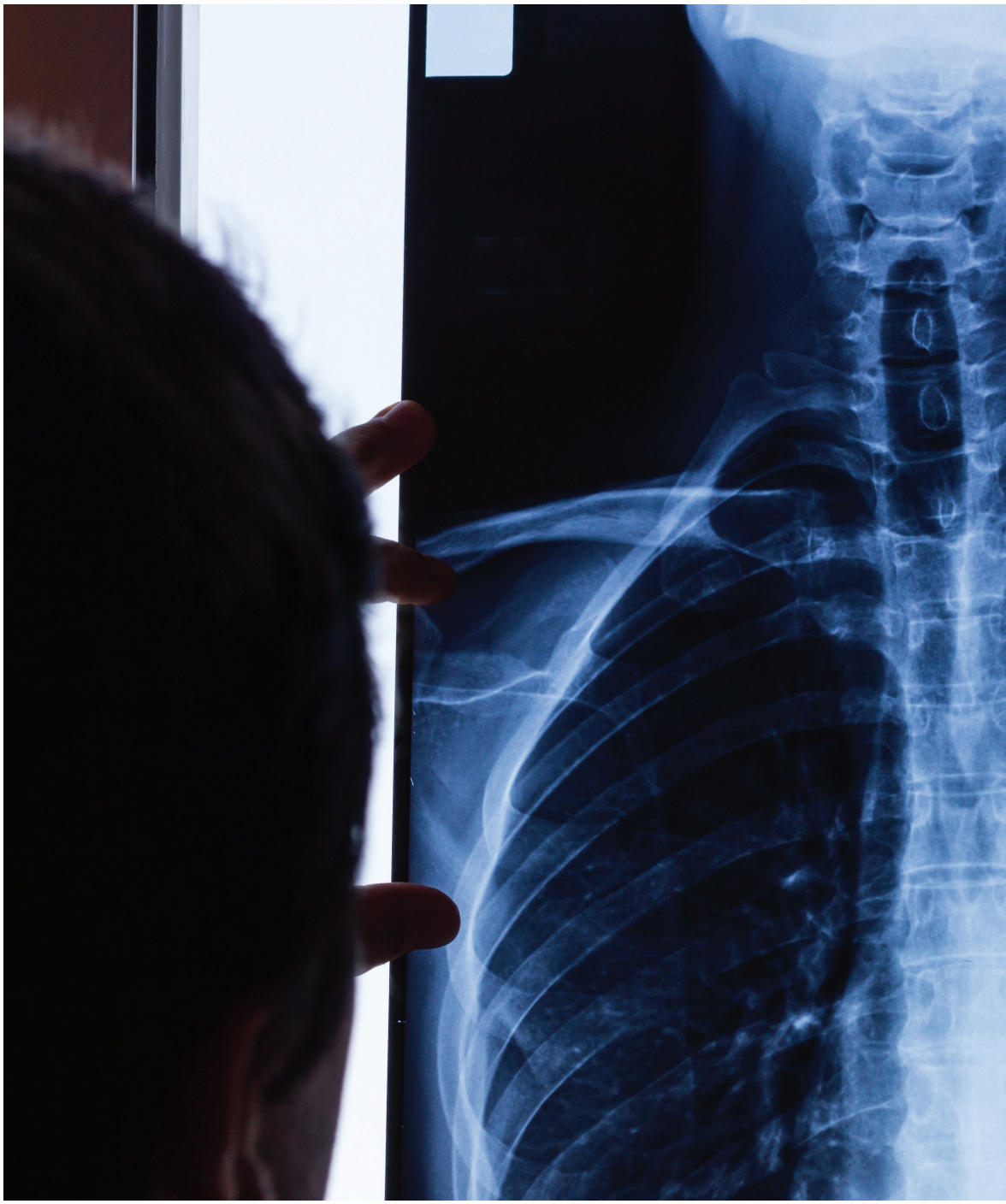
06

Continue strict compliance of narcotic contract enforcement, obtaining regular urine toxicology screening, and checks with prescriptions monitoring programs (CURES).

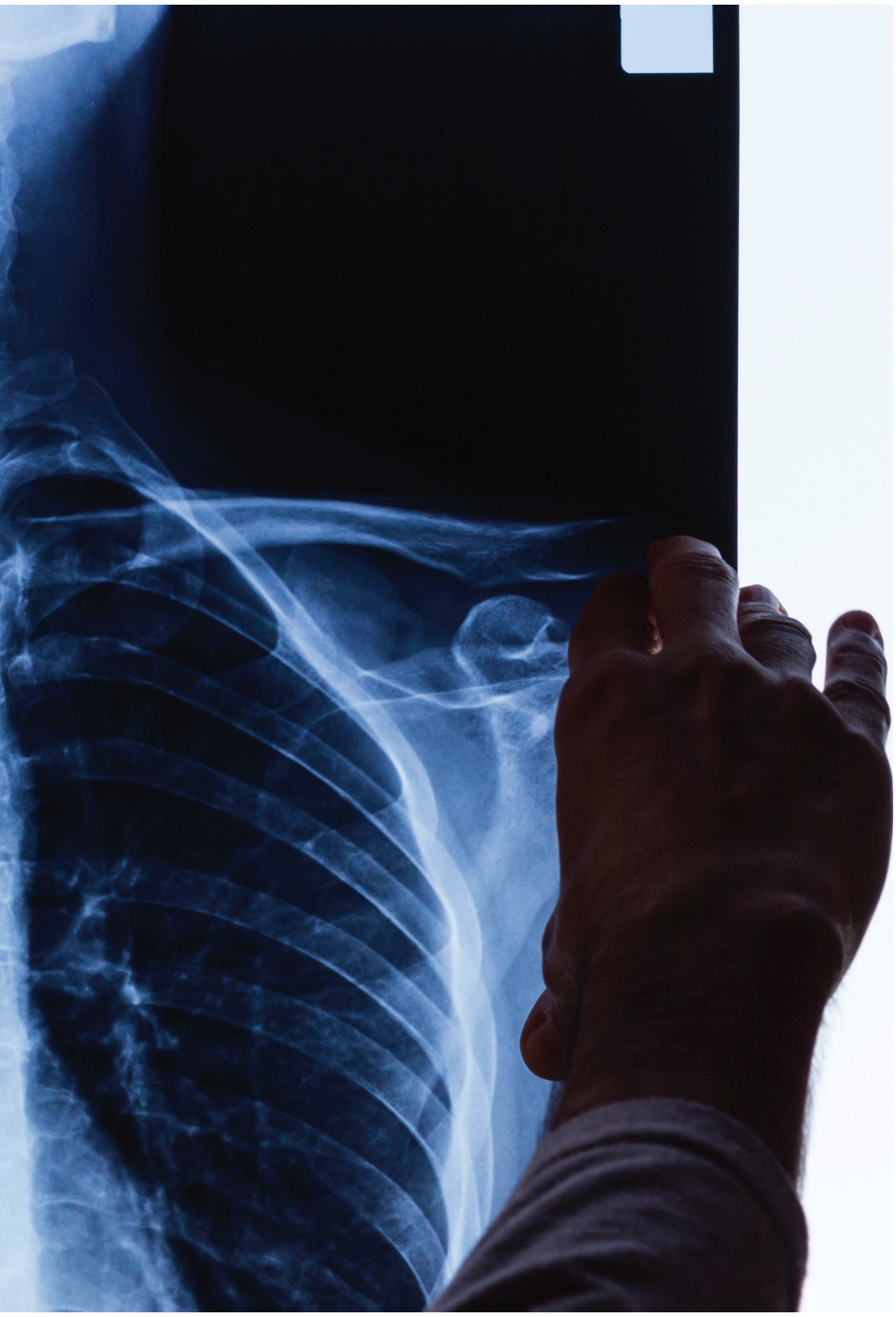
MEDICINE ON TRIAL

Jury Solves Mystery of Retained Foreign Object

While it is not unusual for a retained foreign object to move around a bit, some apparently can travel farther than others.



Gordon Ownby, JD
General Counsel, CAP



A gentleman in his mid-60s presented to the hospital for a total knee replacement. Dr. A, the anesthesiologist, had significant difficulty and made several attempts to place a needle for spinal anesthesia before seeking assistance from a colleague. Together, they were able to place a needle using a straight-in approach.

The surgery was completed without further difficulty and with no apparent anesthetic complications.

Two months later, Dr. A learned that a foreign body had been found in the patient's lumbar spine after an MRI had been ordered as part of a sciatica workup. Reportedly, the MRI was compared to spine films from three years earlier, which showed no foreign body. The patient was advised of the finding and Dr. A discussed a subsequent CT report with him.

Six weeks later, the patient underwent lumbar surgery. The surgeon removed a 2.1 cm "needle" from the spinal canal at L2-3, performed a fusion at that location, a posterior osteotomy, partial reduction/ decompression of spondylolisthesis, partial laminectomy, bilateral foraminotomy and nerve root decompression, pedicle screw fixation, placement of bilateral rods, and a bone graft.

continued

After the surgery, the patient reported relief of his pre-operative pain symptoms but complained of atrophy and lower extremity weakness. The patient did not return to work and was terminated from employment the next year.

The patient filed suit against Dr. A, alleging that she placed a needle through the spinal canal and through the dura, causing the needle to break and lodge in his spine. The plaintiff further alleged it was negligence to fail to recognize a needle fracture when the needle and introducer were removed.

The litigation was initially worked up on the assumption that the foreign body removed in the lumbar surgery was a needle fragment from the anesthesia administered for the knee surgery. The spinal surgeon testified that he could not state whether the patient's pain was from the "needle" or from the patient's pre-existing spinal stenosis, but that in any case, the object needed to be removed.

Discovery revealed that the plaintiff had an urgent consult with a neurosurgeon three years earlier for severe leg pain, back pain, and a foot drop after moving pavers during some home landscaping. That neurosurgeon ordered flexion and extension films and had planned, depending on the films, to recommend surgery at L2-3 or L4-5, but the patient never returned.

During the litigation, however, further examination of the foreign object showed that it bore no resemblance to a spinal needle and matched nothing used in the needle drawer at the hospital where Dr. A administered the anesthesia.

During the workup of the case, Dr. A's defense counsel questioned the plaintiff if he had received medical treatment during a trip that he had made to India three years prior. The plaintiff denied receiving surgical care in India during that time.

Defense counsel then obtained from India samples of cannulas used by physicians in that country. The samples matched the object removed from the patient. Despite the finding, the plaintiff's counsel refused to dismiss the case, but instead presented an expert who theorized that Dr. A used some blunt needle as an introducer which broke and that the fragment was pushed by a spinal needle through to the ligamentum flavum.

At trial, Dr. A's defense attorney proposed that the plaintiff traveled to India after suffering from stenosis and underwent either minimally invasive spine surgery or an epidural injection, and it was then that the foreign object was introduced and retained. In trial, the plaintiff testified that he had no procedures performed after hurting his back while landscaping his yard three years earlier because his back got better by itself.

When Dr. A testified at trial, her defense attorney asked her if she could think of a theory other than that put forward by plaintiff's expert. Dr. A responded that she had done some research into the matter and learned that physicians in some Commonwealth countries, like the former British colony of India, use cannulas in their suction procedures.

After 12 days of trial, the jury deliberated for one day to give a defense verdict to Dr. A by a vote of nine to three.

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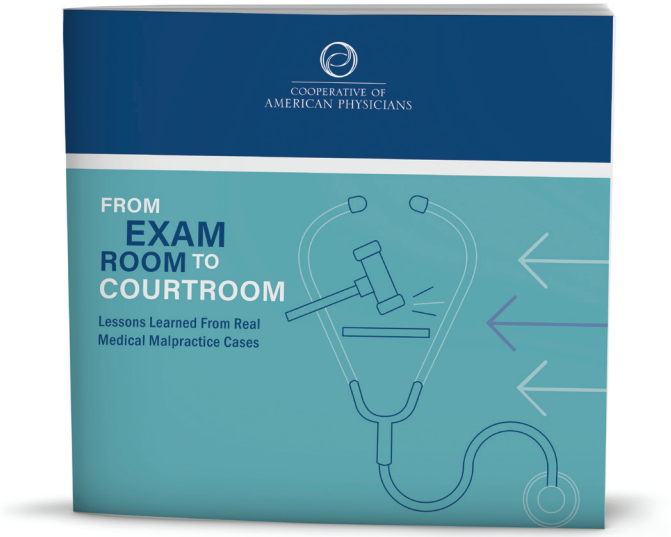

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