THE QUARTERLY PUBLICATION FOR CAP MEMBERS

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COOPERATIVE OF AMERICAN PHYSICIANS

Case of the Month

Don't Overlook Your EHR Reminders

by Gordon Ownby

Physicians in the operating room know that "alarm fatigue" is a real thing that must be taken seriously. With the advent of electronic health records, office-based practitioners must also fight complacency with system-generated reminders for regular patient testing.

The earliest records of the patient's care with the medical group for Dr. FP, a family practitioner, showed a "Patient Profile" that displayed hand-filled dates for mammograms in 2006 and 2010, and cholesterol and other labs in 2006. The health screening field in the profile for sigmoidoscopy was blank for this period.

In 2011, the patient was hospitalized for abdominal pain after a laparoscopic cholecystectomy. The hospitalization included an ERCP and her discharge summary noted a resolved ileus, resolved pancreatitis, erosive duodenitis, hypertension, and diabetes. A review of the hospitalization shows no evidence of a colonoscopy or of any suspicious masses in the colon.

In Dr. FP's first visit with the then 73-year-old patient following that hospitalization, Dr. FP addressed complaints of bronchitis, hypertension, and hyperlipidemia. The patient's visits to Dr. FP and the primary care group over the next year addressed the hypertension, cholelithiasis, mammogram testing, osteoporosis testing, and likely mild diffuse fatty liver disease. At one point in that first year, Dr. FP's chart includes a health plan-generated page titled "Selected Member" with a "Quality Measure Data" box identifying "COLO SCRN, GLAUC SCRN." That record for that visit shows no discussion with the patient on colon screening or any such order for the patient.

The patient continued to see Dr. FP for various complaints and follow-ups. Despite the "Quality Measure Data" sheets noting colon screening (among other tests) being included in the charts for those visits, no colon screening tests were ordered. At one point, Dr. FP's orders included "Screening for malignant neoplasm, colon" with a fecal globin by immunochemistry to be performed. That collection was normal. The form for "colo scrn" was again included in the chart for that visit but no colonoscopy was ordered.

The patient continued to visit Dr. FP and his partner at the medical group several times a year for various complaints for another six years. The records show no discussion with the patient for a colonoscopy. On

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visits over several of those years, identical language is used in Dr. FP's EHR chart to describe a review of systems indicating abdominal pain and bloating yet (incongruously) an exam stating the abdomen is non-tender with no masses and no hepatomegaly.

Some eight months following her final visit to Dr. FP, the patient went for a well-woman exam at a different medical group after moving to a new town to be closer to a daughter. The attending physician noted that the patient needed a mammogram and was overdue for a colonoscopy.

Five months later, the patient visited the ER reporting diarrhea for three weeks. An abdominal and pelvis CT showed inflammatory changes in the transverse colon suspicious for colon carcinoma. A subsequent colonoscopy performed in follow-up found a friable polypoid apple-core lesion in the transverse colon taking up approximately 80 percent of the lumen. The biopsy revealed a poorly differentiated carcinoma and a CT-guided liver biopsy indicated metastatic adenocarcinoma, likely from the colon. Chemotherapy was initiated but the patient died two months later.

With no explanation available from Dr. FP for not ordering a colonoscopy or for not addressing the numerous chart reminders, the litigation initiated by the patient's family was resolved informally.

Like an anesthesiologist disabling an audible alarm, an office practitioner who misses repeated EHR notices puts a patient's safety at risk — and will face any litigation with an inflammatory medical record. Implementing office policies and systems to make sure that all EHR alerts receive a direct response is the place to start to avoid those risks.

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

CAP and MPT Elections, Annual Meeting on July 21

The elections for the Cooperative of American Physicians, Inc., Board of Directors and for the Mutual Protection Trust Board of Trustees will be held on July 21, 2021, in conjunction with the Annual Meeting of Members that same day. The meeting will be held at 333 South Hope Street, 8th Floor, Los Angeles, at 1:00 p.m.

Nominees placed by the CAP Board of Directors for the CAP Board election are Sheilah Clayton, MD; Roger Eng, MD; Wayne Kleinman, MD; John Kowalczyk, DO; Othella T. Owens, MD; Stewart Shanfield, MD, and Lisa Thomsen, MD.

Nominees placed by the MPT Board of Trustees for the MPT Board election are Sheilah Clayton, MD; Roger Eng, MD; Wayne Kleinman, MD; John Kowalczyk, DO; Othella T. Owens, MD; Stewart Shanfield, MD, and Lisa Thomsen, MD.

The CAP ballot, MPT proxy, and additional voting information will be mailed in late May to all CAP members of record on the date of mailing.

Physician Adaptability and Resilience in the Face of COVID

by Gwen C. Spence, MBA

Early in 2020, it was as if a COVID-19 atomic bomb had been dropped. There was disbelief, panic, and confusion in the medical environment. Almost immediately there was a sudden surge of patients seeking medical assistance from emergency rooms for the treatment of COVID-19. Primary care practices were silent with the majority of patients too afraid to seek care from their primary care physicians and bound by stay-at-home orders. As a result, practices furloughed or laid off key personnel and temporarily or permanently closed offices. Primary care physicians were daunted by the task of developing a plan to survive and see patients without spreading the highly contagious virus. Surgical specialties were grounded. Executive orders by the State of California mandated that surgeries and intensive procedures could proceed only if delay was deemed to cause significant impact on health.

According to the Medical Group Management Association, COVID-19 had a financial effect on 97 percent of the 724 practices it surveyed. All medical practices have been affected by at least 50 percent.

As terrible as the pandemic has been, with its sweeping devastation to medical practices, COVID-19 has prompted physicians to develop new systems and procedures to treat patients. As a result, physicians have turned their shrinking practices into busy offices providing vital services to patients.

Telemedicine

Who would have known that doctors would utilize telemedicine on such a wide scale? Telemedicine has been an available method of maintaining a patient/physician relationship since the late 1950s. It has been utilized most often by psychiatrists; however, because of the pandemic, most specialties have found value in the platform. Routine primary care visits, pre- and post-surgical visits, even physical therapy sessions have proven to be effective forms of treatment using telemedicine.

Patient Visits

Many physician offices, especially pediatric practices, have set up alternate ways of checking in office appointments. An appointment is established. The patient reports to the office parking lot, at which time a call is made to the office for "check-in." The office acknowledges the arrival and instructs the patient to wait in the car. When the office is ready, the patient is called on a cell phone with instructions to enter a designated "in-only" door. Upon entering, the patient is escorted directly to a sanitized exam room. When the visit is completed, the patient leaves by a door that is designated "out-only." Efficient and safe.

Some physicians have clothed themselves in personal protective equipment with shields, masks, and gloves to administer vaccines to children who are in their cars in the parking lot. Others have taken to visiting patients in their homes.

Physicians Expand Their Scope of Practice

Anesthesiologists have been invited to assist in COVID-19 intensive care units as a result of their regular tasking of intubating patients who need to go on ventilators. They have found a way to continuously use their training while assisting in a vital situation.

General medicine, family medicine, and internal medicine specialties have been called into emergency rooms for help managing the triage process in hospitals that have been inundated with overflow due to COVID-19. Those that are willing to take the risk of infection have gladly accepted the opportunity to continue to practice. Other physicians have pointed out that partnerships with the military during a situation such as this pandemic can provide additional opportunities to practice that may not otherwise be available.

Physicians and healthcare professionals have proven the theory of adaptability and resilience by becoming better than they were before the pandemic. Due to the unbelievable circumstances of COVID-19, many have

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recreated the manner in which they treat patients by expanding their scope of practice and integrating new ways to extend care while remaining connected to their patients.

Gwen Spence is Assistant Vice President, Membership Services for CAP. Questions or comments related to this article should be directed to gspence@CAPphysicians.com.

Affordable Insurance Benefits Now Available for CAP Member Practices

Providing valuable insurance benefit options for your employees is one way to help keep your practice operating smoothly. Your staff are one of your most valuable assets and when they have peace of mind about their personal well-being, they will have more energy to devote to you and your patients. Additionally, there are a few other enticing reasons why a comprehensive benefits package is good for your practice:

1. Good health-related coverage helps attract and retain quality employees.
2. Businesses get the tax advantage of deducting plan contributions.
3. Employees will often accept better benefits in lieu of a higher salary.

Through CAP Physicians Insurance Agency, Inc. (CAP Agency), employees of CAP members may take advantage of valuable insurance benefits offering significant cost savings on critical coverages that a physician's practice could not typically secure independently. This is because we can leverage the group buying power of CAP's 12,000 members to access great rates.

Through this program, the following benefits are available to your staff:

- **Hospital Indemnity Insurance:** Helps cover costs of a hospital admission that may not be covered by other insurance.
- **Vision Insurance:** Three levels of coverage available.
- **Dental Insurance:** Offers a vast network of preferred dentists.
- **Critical Illness Insurance:** Protects your family from the financial impact of a critical illness.
- **Accident Insurance:** Helps pay for unforeseen bills after a serious accident.

Whether you already have an employee benefits program in place or have avoided adding benefits due to budget concerns, you may be surprised by the preferred low rates you can get from CAP Agency's programs, which are specially designed for smaller practices.

Plus, these programs provide unique features and extensive coverages that can be taken advantage of, in most cases, with no health exams and no waiting periods — and enrollment can take place at any time.

If you are interested in learning more about these plans, please reach out to your CAP account manager or visit this web address: **https://www.CAPphysicians.com/sites/default/files/CAP-OpenEnrollment-Staff-2021.pdf**. You can get started simply by requesting a side-by-side comparison of your current plan benefits with those offered through CAP Agency and our business partner Ashbrook-Clevidence, so you can get a good idea of the expected improvement in coverage and savings. Contact CAP Agency at 800-819-0061(press 5 to reach Benefits) or via email at Benefits@CAPphysicians.com.

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Risk Management and Patient Safety News

But… I'm Not with Them

by Amy McLain, BSN, RN

Do you have an "independent contractor" physician or practitioner seeing patients in your medical practice? Do you allow an outside service to perform ultrasounds, bone density scans, lab work, aesthetic treatments, or other services in your medical practice? If the answer is yes, you may be liable for that person's actions.

CAP understands the various reasons why you would enter professional relationships with other physicians and practitioners through your medical practice. Usually, it is to increase the range of medical services offered to patients, which increases the potential patient population and resulting revenue. Understandably, it can be to offset the expenses of doing business and to share resources.

You likely understand that when entering a formal written partnership, you can be held liable for the negligence or misconduct of a partner. But did you know that even if no formal legal partnership exists, you can expose yourself to liability when, by your actions and declarations, you give the impression of a joint medical practice? This is called Ostensible Agency.

Black's Law Dictionary defines Ostensible Agency as, *"An Implied or presumptive agency, which exists where one, either intentionally or from want of ordinary care, induces another to believe that a third person is his agent, though he never in fact employed him. Bibb v. Bancroft (Cal.) 22 Pac. 484; First Nat. Bank v. Elevator Co., 11 N. D. 280, 91 N. W. 437."*

Consider this scenario: You are a physician owner of an ophthalmology practice named VisionCare. As an expanded service to your patients, an "independent contractor" optometrist (Dr. I) comes to your office to provide refractive services. Mrs. Goingblind presents to VisionCare because she has trouble seeing. Dr. I examines her and misses the early signs of toxoplasmosis. As a result, Mrs. Goingblind loses all left

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eye vision. She sues VisionCare for the optometrist's negligence, even though Dr. I is not a VisionCare employee and Dr. I has his own malpractice coverage.

How would Mrs. Goingblind know that Dr. I is not an employee/partner of VisionCare? She wouldn't — unless after walking through the office door, there was evidence that Dr. I was not part of VisionCare. Under the rules of Ostensible Agency, she need only perceive that he is an employee or partner in VisionCare to entangle the group in a lawsuit for the diagnostic error.

Simply put, you may be targeted for the malpractice of physicians and practitioners you do not employ or formally partner with. Absent diligence on your part, all it takes is a patient or his or her family to misinterpret and believe that there is a professional employee/employer or partnership between you and them. Furthermore, there are even instructions for juries to find you liable.

To reduce your Ostensible Agency liability, CAP recommends that when sharing office space with other physicians and practitioners who are not part of your medical practice, you should follow these risk reduction strategies:

- Be alert to those situations when your words or actions can create the impression you "rely" on someone else's reputation for service or expertise.
- Educate patients that your medical practice is separate from those other physicians and practitioners. Inform your patients that you are not responsible for each other's patients or medical practices. Make it part of the intake discussion. Post a notice at the reception desk, on your website, and in your practice materials.
- Compile a list of those physicians and practitioners and have patients sign that list attesting that they understand that the physicians/practitioners in the office are not partners or otherwise affiliated. Make it part of the patient's medical record.
- Avoid regularly seeing each other's patients (except on an emergency basis). But if you decide to, keep separate medical records and charge patients of other physicians or practitioners separately.
- Use the words "a separate medical practice" under each doctor's name on the front door for those sharing office space and resources with other physicians and practitioners.
- Use separate employees, when practical.
- Arrange your business needs separately — i.e., rent, accountant, insurance, etc.
- Use separate prescription pads and business cards.
- Use separate business letterheads.
- The outside practitioner should invoice his or her medical care separately from your invoices.
- Lab coats and ID badges should be identified separately for such outside practitioners.

This information is provided as a service to CAP members from a risk management perspective and is not intended as legal advice. If you have questions or a specific patient situation and need guidance please contact the Hotline at (800) 252-0555.

Amy McLain is Vice President, Risk Management and Patient Safety for CAP. Questions or comments related to this article should be directed to amclain@CAPphysicians.com.

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Black's Law Dictionary 2nd Ed. Accessed 2/22/2021

https://thelawdictionary.org/ostensible-agency/

Recall Election Adds to Governor's To-Do List

by Gabriela Villanueva

In the coming weeks and months, California Governor Gavin Newsom will continue to toggle his attention between pandemic-related policies, business and school reopenings, expanding vaccination availability, and a likely fall recall election.

Registrars across California's 58 counties have until the end of April to complete the voter signature validation process and certify if recall proponents reached the 12 percent threshold of total votes cast in the 2018 gubernatorial election to qualify the recall proposal for the ballot. If qualified, the final decision on when to hold a recall election would fall to Lieutenant Governor Eleni Kounalakis, who would be required to schedule the contest 60 to 80 days after the final certification of voter signatures. Based on this proposed timeline, a recall election will likely take place anytime between September and November of this year. Such timing could benefit Governor Newsom given the potential for increased optimism for a more "normal" California, as its residents get their COVID-19 vaccinations.

Meanwhile, back on February 23, as Congress negotiated President Biden's COVID-19 relief package, the governor signed his own $7.6 billion COVID-19 relief package providing urgent relief to those in the state who have continued to be greatly impacted by the ongoing pandemic. The package builds on the initiatives in the Governor's January state budget proposal to provide cash relief to lower-income Californians, increase aid to small businesses, and provide license renewal fee waivers to businesses impacted by the pandemic. In addition, the legislation also commits additional resources for childcare services and funds for emergency financial aid for community college students.

Governor Newsom, elected in 2018 with 62 percent of the vote, has acknowledged mistakes in his handling of the coronavirus pandemic. Speaking to the Associated Press on March 18, a year's time from the first-in-the-nation statewide lockdown, Governor Newsom addressed reopening modifications put in place after a mid-summer surge in infections and hospitalizations. "We were communicating with counties and businesses and sectors and industries, not with the public, what that modification meant and what it didn't mean," he said. "And in hindsight, clearly, we could have done a much better job by informing the public what those modifications meant."

On the question of the recall, though, Governor Newsom insists the effort against him has more to do with politics than the public health crisis.

"It's about immigration. It's about our healthcare policies. It's about our criminal justice reform. It's about the diversity of the state," Governor Newsom told Bay Area public radio station KQED in March. "It's about our clean air, clean water programs, and meeting our environmental strategies."

Gabriela Villanueva is CAP's Government & External Affairs Specialist. Questions or comments related to this article should be directed to gvillanueva@CAPphysicians.com.

Public Policy

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