



## Announcing the 2019 CAPtivating Causes Community Hero and Community Leadership Award Winners

Earlier last year, CAP solicited nominations for the organization's first-ever Community Hero Award to highlight the work of a CAP member whose charitable service merits special recognition. The award includes a \$5,000 grant for the charitable organization affiliated with the physician's work. One runner-up will receive the Community Leadership Award, which includes a \$1,000 grant for the recipient's associated charity.

"The response was impressive, and each nomination was well worthy of consideration," said CAP CEO Sarah E. Scher, JD. "Our selection committee had a very difficult task of selecting the awardees, and we're proud to announce them."



### COMMUNITY HERO AWARDEE

**Paula R. Dhanda, MD**  
CAP Member Since 1990  
Gynecological Surgery  
Kelseyville, California

Paula R. Dhanda, MD, FACOG, FACS, is well known for her many years of service to the women of Lake County as well as internationally, through her nonprofit organization, Worldwide Healing Hands, a registered non-profit 501(c)(3) organization. Dr. Dhanda has successfully dedicated her life to improving the health of her local and global community.

As a young girl growing up in Bombay, India, she witnessed extreme poverty first hand and watched her surgeon father serving the city's large indigent population. In 1990, she decided to follow in her father's footsteps and moved to Lake County where there was a physician shortage. There, she established a state-of-the-art obstetric program and introduced many new technologies to the area, including minimally invasive surgery.

Dr. Dhanda began her international initiative in 2009 when she was invited by a fellow surgeon to participate in a medical mission in Chad, Africa. In response to the tragic need that she witnessed during her time there, she created Worldwide Healing Hands.

She has subsequently led medical teams on missions all over the world, including Haiti, Nepal, Uganda, and Cambodia. Dr. Dhanda created clean birth kits and produced a film called "Helping Babies Breathe" which is distributed widely to teach neonatal resuscitation to physicians, midwives, and traditional birth attendants. Participants in her classes are also given resuscitation equipment, and her teams have trained over 200 doctors, midwives, and nurses.

For more information about Worldwide Healing Hands, please visit <https://worldwidehealinghands.org/>



## COMMUNITY LEADERSHIP AWARDEE

**Gudata S. Hinika, MD**

**CAP Member Since 2001**

**General Surgery**

**La Cañada Flintridge, California**

Dr. Gudata Hinika is the Chief of Trauma, General, and Critical Care Surgery at California Hospital Medical Center, the busiest private trauma center in Los Angeles. Throughout his career, Dr. Hinika has dedicated his life to alleviating adverse health conditions in underserved communities. His commitment extends far beyond hospital walls locally and globally.

Dr. Hinika is the Founder and CEO of Ethiopia Health Aid (EHA), a 501(c)3 organization with a mission to build healthy, self-reliant communities in rural Ethiopia through education, health, and action. He founded the organization in 2007 after seeing hundreds of people in Oromia die from easily preventable diseases or conditions that could be treated with proper equipment and training. He and his wife Wubitu started the process of building a hospital in the town of Negele Arsi, and the hospital opened in July 2017.

Getting the facility built was only the first step; the hospital still needed specialists and training for its staff. Dr. Hinika started organizing missions to Negele Arsi in 2011. At first, that involved taking people almost 200 kilometers outside of Negele Arsi by bus to other treatment facilities. The hospital now has a full-time staff and more ambulances are in place, so visiting doctors do not have to take those steps.

EHA takes volunteers to Oromia about twice a year to perform medical services. The Negele Arsi Hospital is also setting up a health college to train 200 nurses and medical workers.

For more information about Ethiopia Health Aid, please visit <http://ethiopiahealthaid.org/>

**Congratulations, Dr. Dhanda and Dr. Hinika!** ➦

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# Risk Management — and — Patient Safety News



## Security Cameras in the Medical Office

by Michael D. Valentine, JD, CPHRM

Security cameras have become part of the public landscape, but do they have a place in the medical office? This article will provide an overview of the issues connected with installing video cameras in the office and a framework for deciding whether such surveillance might fit your practice.<sup>1</sup>

Attitudes toward video vary. Some consider it a violation of their privacy, while others love posting videos on social media. Regardless of perspective, it is generally acknowledged that security cameras can help prevent unsafe incidents and all would agree that office safety is important to patients, doctors, and staff.

There are no specific federal laws that outline exactly what, where, and how safety video surveillance can be used in a medical office. California law states that cameras cannot be used where individuals have a “reasonable expectation of privacy” but does not specifically address medical offices. Moreover, the California Medical Board, California Medical Association, and American Medical Association have not published official positions on office security cameras. Without such explicit guidance, a physician’s efforts to promote a safe location must be carefully balanced with the obligation to safeguard Protected Health Information (PHI) under HIPAA and other laws. So, where should you begin? It is always best to start with a written policy. Here are some elements to include in a policy:

- **Purpose** — Start with the legitimate purpose for use of a security camera system. Presumably, it is for patient, staff, and physician safety and security.
- **Locations** — Security cameras should be visible – not concealed – and are only allowed in the

“public” or common areas (such as the waiting room) and cannot be placed in exam rooms, bathrooms, or other areas where people have a reasonable expectation of privacy. Hallways may be more problematic because of the possibility of the camera’s view extending into an exam room. Cameras should be positioned to avoid view of PHI, such as charts or computer monitors.

- **Employees** — Make sure that employees know there are security cameras. Employees should sign an acknowledgement of the use of cameras, especially if there are cameras in employee work areas – such as a nurses’ station – where workers may have some expectations of privacy. Do not place cameras in employee lunch or break rooms.
- **Audio** — The security system cannot include audio. Audio surveillance is considered eavesdropping and may be a violation of California Penal Code 632.
- **Postings, notification** — Signage stating that there is a nearby security camera should be placed. This discourages claims that someone reasonably expected the area to be private and supports the legitimate purpose — safety. If five percent or more of your patients speak another language, the signage also needs to be in that language.
- **Archiving** — To be consistent with the safety purpose of video surveillance, it is likely you will not need to keep video files for very long. Indeed, safety-purposed video is frequently recorded over or regularly purged. You’ll need to plan how footage showing an incident will be maintained.

January 2020

Determine who will be responsible for managing the system, who will have access to the files, and under what circumstances.

- **Security** — The system must be secure, both physically (i.e., locked in a cabinet) and digitally (i.e., password protected).
- **Privacy considerations** — A patient's visit to the doctor's office is considered PHI and subject to HIPAA regulations. Therefore, if there is an incident, the identities and images of innocent bystanders will need to be protected.

We hope that these considerations provide a useful

entrée into using video to help create a safe office environment. In the unfortunate event of an incident, we encourage our CAP members to call the CAP Hotline at 800-252-0555. ➦

*Michael Valentine is a Senior Risk Management and Patient Safety Specialist for CAP. Questions or comments related to this article should be directed to [mvalentine@CAPphysicians.com](mailto:mvalentine@CAPphysicians.com).*

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<sup>1</sup>This article is not intended as legal advice and no attorney-client relationship is intended or should be implied. This article is intended as a general overview and a starting point on the issue of medical office video surveillance. Please consult an attorney for advice regarding your actual practices and policies for security cameras.

## Let CAP Agency Take the Guesswork Out of Your Insurance



Are you using multiple insurance agents to protect your business? Are you trying to save a few dollars by buying your business owner, workers' compensation, and auto insurance through various agents or insurance companies? You're not alone — almost half of small business owners use more than one insurance market — but you may be putting your business at risk. If something goes wrong, do you know whom to call? More importantly, are you sure you're adequately protected to prevent a loss in the first place?

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# 2020 California Healthcare Law Highlights

by Gabriela Villanueva



Governor Gavin Newsom's very public budget focus on healthcare will gain statutory support in 2020 following a slate of healthcare funding bills passed by the Legislature.

The following highlights many of the laws effective January 1, 2020, that will affect physicians, from the business operations of their medical office to actual patient care.

New laws affecting the workplace include:

## **AB 5: Re-classification of Workers with ABC Test**

The bill codifies a ruling from the California Supreme Court that included a new test restricting workplace determinations for individuals seeking to work as independent contractors. A coalition including the California Medical Association successfully secured an exemption for physicians from the legislation. Dentists, podiatrists, psychologists, and veterinarians were among those also securing exemptions. However, other healthcare workers, including physician assistants, nurses, and behavioral health providers, still fall within the scope of the new law.

## **AB 51: New Arbitration Law in California**

This prohibits mandatory employment arbitration agreements (with limited exceptions). It will be important for employers who wish to use arbitration agreements (or jury trial or class action waivers) in California to ensure that employees voluntarily and affirmatively elect to enter into such agreements. This may require some employers to revise their agreements and to implement new practices.

## **SB 778: Sexual Harassment Avoidance Training Extension**

This requires an employer with five or more employees to provide sexual harassment avoidance training and education by January 1, 2021 and thereafter once every two years. The new law requires that new nonsupervisory employees be provided sexual harassment avoidance training within six months of hire. New supervisory employees (including physicians)

must be provided sexual harassment avoidance training within six months of assuming a supervisory position. The law clarifies that an employer who has provided this training and education in 2019 is not required to provide it again until two years thereafter.

New laws affecting access to healthcare coverage include:

## **Health Coverage Subsidies**

Through the passage of the annual budget bill, the state will begin to provide subsidies to pay for health plans on the state insurance exchange. In addition to federal subsidies for Covered California health plans, eligible residents will also receive an additional state-funded subsidy. Also starting in 2020, state residents who are uninsured for more than three months will be hit with a tax penalty for not having coverage. California is now the first state to impose an "individual mandate" previously required under the Affordable Care Act.

## **SB 159: HIV Prevention Drugs**

California will be the first state to allow people to access HIV prevention drugs from pharmacies without a doctor's prescription. Pre-exposure prophylaxis (PrEP) is a once-a-day pill for HIV-negative people that may keep them from becoming infected; post-exposure prophylaxis (PEP) is medication that can help prevent the virus from taking hold if an individual has been exposed. SB 159 by state Senator Scott Wiener (D-San Francisco) will allow pharmacists to dispense a 60-day supply of PrEP, or a 28-day course of PEP. Patients will need to see a physician to obtain more medication. The bill prohibits insurance companies from requiring patients to obtain prior authorization before obtaining the medication.

## **AB 744: New Telehealth Parity**

AB 744 will require contracts issued, amended, or renewed after January 1, 2021, between a healthcare service plan and a healthcare provider to specify that the provider who delivers services appropriately through telehealth be reimbursed on the same basis and to the same extent that the plan would have had the same service been provided in-person. The



## Following Up on First Impressions

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 US report noted "mild 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 take-away 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

Continued from page 6

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. ➦

*Gordon Ownby is CAP's General Counsel, and this month marks 20 years of his "Case of the Month" column. We thank the CAP members who have made "Case of the Month" a regular reading habit. Questions or comments related to "Case of the Month" should be directed to [gownby@CAPphysicians.com](mailto:gownby@CAPphysicians.com).*

Continued from page 5

health plan cannot require the use of telehealth if the healthcare provider has determined that it is not appropriate. Also, the new law does not limit the ability of the health plan and provider to negotiate the rate of reimbursement for a service.

### **SB 600: Fertility Treatments**

Some Californians undergoing cancer treatment such as radiation or chemotherapy will have insurance coverage for fertility preservation treatments. Private health plans regulated by the state must cover procedures such as the freezing of eggs, sperm, or embryos for patients undergoing therapy who want to try to have children in the future.

### **SB 276 and SB 714: Medical Exemptions for Immunizations**

- SB 714 will allow a child with a medical exemption issued before January 1, 2020, to continue enrollment with current exemption until the child enrolls in the next grade span.
- SB 276, effective January 1, 2021, directs the California Department of Public Health (CDPH) to develop and make available for use by licensed physicians and surgeons an electronic, standardized, statewide medical exemption certification form that shall be transmitted directly to the department's California Immunization Registry (CAIR). CDPH will review annually exemption forms that meet any of the following criteria: 1) submitted to schools with overall immunizations rates less than 95 percent; 2) submitted by physicians who have submitted more than five medical exemptions in one year; or

3) submitted to schools that have failed to report their immunization records to CDPH.

- The State Public Health Officer or a physician designee may deny or revoke medical exemptions that do not align with CDC/ACIP or AAP guidelines.
- The Department will notify the Medical Board of California of any physician who submits an exemption that is denied or revoked, and of any physician from whom the Department is not accepting exemptions.

### **SB 1448: Probation Status Disclosure**

The first-in-the-nation law requiring physicians and surgeons to notify their patients if their license is on probation passed in 2018 and went into effect July 1, 2019. Patients must be notified of the following offenses (the new law also applies to naturopathic doctors, chiropractors, podiatrists, and acupuncturists):

- Any act of sexual abuse, misconduct, or relations with a patient or client;
- Drug or alcohol abuse directly resulting in harm to patients or to the extent that such use impairs the ability of the practitioner to practice safely;
- Criminal conviction directly involving harm to patient health; or
- Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.

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## IN THIS ISSUE

- 1 Announcing the 2019  
CAPtivating Causes Community Hero and Community Leadership Award Winners
- 3 Risk Management and Patient Safety News  
*Security Cameras in the Medical Office*
- 4 Let CAP Agency Take the Guess Work Out of Your Insurance
- 5 Public Policy:  
*2020 California Healthcare Law Highlights*
- 6 Case of the Month:  
*Following Up on First Impressions*

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Legal guidance for individual matters should be obtained from a retained attorney.



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