THE MONTHLY PUBLICATION FOR CAP MEMBERS

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Board Elects Dr. Stewart Shanfield to MPT Trustee Position as Dr. Andrew Sew Hoy Retires

Stewart Shanfield, MD

Andrew Sew Hoy, MD

In voting to fill a vacancy created by the retirement of Andrew Sew Hoy, MD, the Mutual Protection Trust Board of Trustees has elected Stewart Shanfield, MD, to join the five-member Board.

Dr. Shanfield is an orthopedic surgeon in Fullerton who served on the Board of Directors of the Cooperative of American Physicians, Inc., from 2007 to 2017.

"Serving on the MPT Board of Trustees is actually an opportunity to better serve fellow physician members," said Dr. Shanfield. "As your trustee, I will work to maintain MPT as a powerful voice in medicine, protect its resources, and provide support to our excellent physicians."

CAP and MPT Chief Executive Officer Sarah Pacini commented on the skills that Dr. Shanfield brings to the Board of Trustees. "In addition to having built an exceptional orthopedic surgery practice, Dr. Shanfield brings a wealth of experience," said Pacini. "He is a former board chair and chief of staff at St. Jude Medical Center, has served on CAP and MPT's Audit and Finance Committees, and has been a Fullerton Community Bank board member since 2001. We're lucky to have his experience, intelligence, and warm sense of humor on our team."

Dr. Shanfield joins Charles Steinmann, MD; Philip Unger, MD; Mearl Naponic, MD; and Othella T. Owens, MD on the Board of Trustees.

Pacini also commented on the Board of Trustees service of Dr. Sew Hoy, who joined the MPT Board in 2009 after serving for many years on the CAP Board of Directors and as an MPT Risk Assessment Peer Review Committee chair.

"MPT benefited greatly from Dr. Sew Hoy's intelligence, insights, and ability to distill the ideas of others to what matters most," Pacini said of the Los Angeles orthopedic surgeon, who retired from the MPT Board on June 30. "Dr. Sew Hoy always acted in the very best interests of all our members."

July 2018

Risk Management
and
Patient Safety News

Medical Cannabis: Know the Latest

Kimberly Danebrock, JD, RN, CPPS

Many physicians feel they are not well informed about the indications, risks, benefits, and side effects of medical cannabis. Considering the inconsistency with federal and state laws and the mixed messages between legislation and government action, it is easy to see why most physicians have opted to avoid the issue until the confusion clears. However, as medical cannabis is being accepted and used by more patients, physicians have a responsibility to expand their current knowledge on the topic.

As humans, we all have biases. However, it is vital that bias not interfere with patient care. Physicians should be able to discuss the warnings of using medical cannabis and recognize the side effects. The reality is, although the stereotypical "stoner" will likely always exist, individuals between the ages of 55 to 65 are the fastest growing demographic starting to use medical cannabis. Technology allows for patients to have access to more information and many individuals are now using medical cannabis for wellness — not to get high. In other words, lumping all cannabis patients together is a disservice to your patients and their care.

While cannabis contains at least 113 cannabinoids, there is only one that gets you high, tetrahydrocannabidiol (THC). Because THC is the psychoactive component in cannabis, patients that use cannabis products with THC may exhibit different and more severe side effects than those individuals using cannabis products without THC.

In contrast, cannabidiol (CBD) is the primary non-psychoactive cannabinoid. Often, cannabis products contain a combination of THC and CBD. However, for wellness, many are choosing products that are solely CBD. Therefore, patients using these products are likely to have minimal to no side effects and they are not getting high.

Under the Federal Controlled Substances Act of 1970, cannabis is classified as a Schedule I drug — which means it has a high potential for abuse, there is a lack of accepted safety, and there is no medically accepted use in the United States. Therefore, physicians who intentionally make certain oral or written statements, or take other actions, for the purpose of assisting patients to obtain cannabis in violation of federal law, may be subject to serious liability. Even in states that have legalized the medical use of cannabis, such as California, providers are subject to federal law prohibiting

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physicians from recommending it to patients. The Ninth Circuit in 2002 ruled (Conant) that physicians have a right to discuss medical cannabis with their patients under the First Amendment as long as they are not aiding and abetting their patients to violate federal drug laws. Therefore, physicians should be cautious if advising patients on medical cannabis. This prohibition should aim the physician away from advising patients as to where they can purchase cannabis and from discussing dispensary options or dosing of products. It is wiser to refer patients to the Internet so they can conduct their own research.

The current recommendations may change in the near future as more research continues, professional organizations recommend the rescheduling of cannabis, patients increasingly demand access to the product, and the recent FDA-approval of Epidiolex, the first plant-based cannabis (CBD only) pharmaceutical in the U.S. in approximately 80 years. However, at least for now, the uncertainty continues. The FDA-approval of Epidiolex does not make all forms of cannabis legal. Each potential cannabis medication would have to go through the same process and become FDA-approved for physicians to prescribe the drug without fear of violating federal drug laws.

Patients who admit to using cannabis should be provided the warnings listed below and all warnings given should be well documented in the medical record:

- Keep cannabis secure and away from children
- If using products with THC, warn against driving under the influence
- Warn high-risk patients, such as minors, those with kidney and liver disease, women who are pregnant or breastfeeding, and those with certain psychiatric diagnoses, that they may be at higher risk for side effects and other complications
- The potential dangers from long-term smoking for those that use this route
- Advise patients to avoid synthetic cannabis products – these can be dangerous, even deadly

In addition to the warnings listed above, patients should be told of the possible side effects of using cannabis.

The majority of side effects are associated with products that contain THC. Side effects associated with cannabis use include:

- Cannabinoid hyperemesis syndrome
- Tachycardia
- Hallucinations, paranoia, anxiety, depression
- Dizziness, decreased balance, coordination, and reaction time
- Hypotension
- Dry mouth, red eyes, hunger

Until the path on medical cannabis becomes clearer, we encourage physicians to continue to enhance their knowledge on this commonly used drug. Since violating federal law could subject a physician to sanctions, it is vital you understand the rules. Please follow the guidelines provided by the Department of Justice, state medical board, and professional organizations. The following resources can assist you in learning more about medical cannabis:

- Stay up to date with federal law by looking at the DOJ's website at www.justice.gov
- Review CMA guidelines at www.cmanet.org
- The California Medical Board's statement on the medical use of cannabis can be found at https://www.mbc.ca.gov/Publications/guidelines_cannabis_recommendation.pdf
- Stay on top of current research by reviewing the Center for Medicinal Cannabis Research at UCSD at www.cmcr.ucsd.edu
- Review and warn your patients against the use of synthetic products https://www.cdc.gov/mmwr/volumes/67/wr/mm6720a5.htm

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Members of the Cooperative of American Physicians should be aware that under the terms of the Mutual Protection Trust Agreement, members will not be covered for claims arising out of the prescription, use, or administration of medications that are not FDA-approved.

The information in this publication should not be considered legal advice applicable to a specific situation. Legal guidance for individual matters should be obtained from a retained attorney.

Kimberly Danebrock is Director of Risk Management for CAPAssurance. Questions or comments related to this article should be directed to kdanebrock@CAPphysicians.com.

Are You Taking Advantage of CAP Resources to Protect Yourself from a HIPAA Violation?

By now, you know that a HIPAA breach not only can be costly and time-consuming, but can also jeopardize your relationship with patients who trust you to safeguard their privacy. Regardless of practice size or scope, no healthcare provider is immune from being penalized for a breach. Just last month, the University of Texas MD Anderson Cancer Center in Houston was ordered to pay over $4.3 million in civil penalties for two HIPAA violations involving breaches of electronic protected health information of more than 33,500 individuals.

While you most likely will never experience a breach of that magnitude, even breaches lesser in scope can significantly impact the finances of a solo practitioner or small group. The good news is you can help reduce the likelihood of a HIPAA violation by taking advantage of the many resources you're entitled to as a CAP member. Here are just a few:

CAP HIPAA Resource Center

You and your staff have access to a number of free HIPAA resources right at your fingertips on the CAP website. We encourage you to visit www.CAPphysicians.com/risk-management/tools-and-resources to download free guides, checklists, and other important documents all designed to keep you HIPAA compliant. These include:

- The 6 Most Common HIPAA Violations (and How to Prevent Them)
- HIPAA Risk Assessment Checklist
- HIPAA Omnibus Rule Checklist
- Sample Notice of Privacy Practices
- HIPAA Compliance Forms
- And more!

HIPAA Security Suite

If you are seeking a simple and affordable single-source solution to achieving and maintaining HIPAA compliance requirements, then look to the HIPAA Security Suite. Through our trusted CAPAdvantage provider, Acentec, you get ongoing risk analysis, a legally reviewed set of current policies and procedures, employee HIPAA training, and more – **all at a 25 percent discount as a CAP member!**

For more information, contact Acentec CEO and Founder **Jeff Mongelli** at **800-970-0402** or **jeffm@acentec.com**. Jeff will happily get back to you within one business day.

In addition to the plethora of HIPAA resources CAP makes available to you, the U.S. Department of Health and Human Services hosts an educational website, www.hhs.gov/hipaa/for-professionals/training, for medical professionals, featuring guides, videos and other resources to help keep you in the know regarding HIPAA compliance.

We hope you take advantage of the valuable CAP benefits intended to protect you from the financial and emotional fallout of a HIPAA violation.

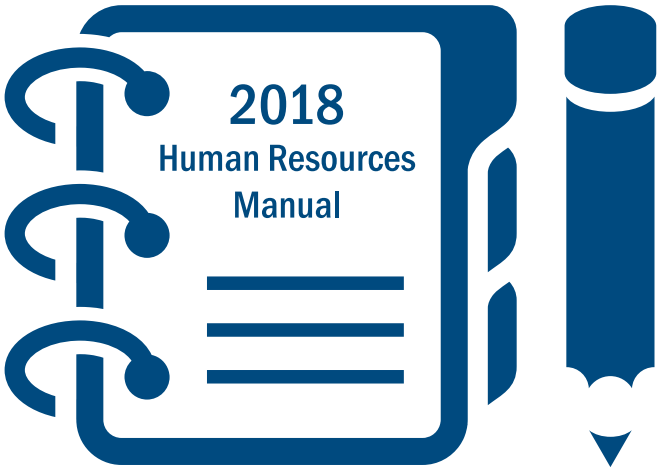
Updated for 2018 – CAP's Free Customizable Human Resources Manual

CAP's Human Resources Department offers a free customizable human resources manual designed to assist you in providing appropriate office policies for the management of your employees throughout the employment cycle. This comprehensive, customizable manual is designed exclusively for medical practices and has been updated with California employment laws as of May 2018.

If you downloaded the previous version of this manual in 2017, you will need to update the policy sections below in order to remain compliant with current laws. The policies listed below need to either be updated or the Editor's Notes for these policies need to be read to determine if the policy should be updated for your practice. When you see a reference to *Editor's Note Only*, please read the Editor's Note to be aware of the policy in general.

General Employment Policy (last paragraph)

Discrimination, Harassment, Violation of the Law: Non-Harassment Policy section: (First two paragraphs and Editor's Notes) and Equal Employment Policy: add transgender "or transitioning" (first paragraph and Editor's Notes)



- Pregnancy Accommodation
- Lactation Accommodation
- Workplace Violence *(Editor's Note Only)*
- Parental Leave *(all new)*
- Domestic Violence, Sexual Assault, or Stalking *(Editor's Note Only)*
- Pay Day/Paycheck Accuracy *(Editor's Note Only)*
- Sick Leave/Kin Care *(First two paragraphs)*
- Dress Code and Personal Appearance *(Editor's Note Only)*
- Keeping Your Personnel File Up to Date *(Editor's Note Only)*
- Employment Application (new) *(Editor's Note Only – Located in the Appendix)*
- Interview Report *(Editor's Note Only – Located in the Appendix)*

If you downloaded a version of the manual prior to 2016, you will need to compare your entire manual for updates.

Download the 2018 Human Resources Manual by logging into the Member's Area of the CAP website. Upon logging in, click on the "HR Manual" tile.

For questions regarding our Human Resources Manual or any HR issue, contact **Nancy Brusegaard Johnson**, CAP's Senior Vice President of Human Resources and Operations, at **213-473-8664** during business hours, 8:30 a.m. to 5:30 p.m.

Fighting Hunger
One Meal at a Time

On June 2, CAP and MPT board members, senior staff volunteers, and their families took part in a worthwhile cause to help fight hunger in the community at the Los Angeles Regional Food Bank. Along with other groups of volunteers, the CAP team inspected, sorted, labeled, and packaged food to be distributed to those in need.

In two and a half hours, the entire group sorted over 11,000 pounds of food donated by food drives and supermarkets that helped build 9,600 meals. These meals, along with other essentials, are distributed to children, seniors, families, and others in need. Community support enables the Food Bank to serve more than 300,000 people on a monthly basis. With an estimated 1.4 million people in Los Angeles County living with food insecurity, volunteer efforts such as these make a huge difference.

In the end, all volunteers were grateful to have the opportunity to help make a difference in the community. For more information about this organization, visit https://www.lafoodbank.org/.

We are very proud of everyone who participated in the Food Drive Sort-A-Thon Project at the LA Regional Food Bank, most notably:

- Dr. Wayne Kleinman
- Dr. Charles Steinmann
- Dr. Sheila Clayton
- Dr. Phil Unger
- Dr. Greg Lizer
- Dr. Graham Purcell
- Dr. Lisa Thomsen and her husband, Chris Martinez
- Dr. Stewart Shanfield
- CAP CEO Sarah Pacini and her daughter, Hannah
- CAP COO Cindy Belcher and her husband, Pete
- CAP CFO John Donaldson and his wife, Kathy
- CAP Senior Vice President, Claims, Jeff Stoner
- CAP General Counsel, Gordon Ownby
- CAP Assistant Vice President, Corporate Communications, Hana Kim
- CAP Digital Communications Specialist, Alex Guerrero

To see images from the event, visit CAP's Facebook page: https://www.facebook.com/CooperativeofAmericanPhysiciansInc.

The Value of Ancillary Benefits

Did you know that 48 percent of employees would change jobs for more benefits? That's half of the workforce, and certainly proof that the benefit package employers offer makes a huge difference in how they stand out with potential candidates in the marketplace (or existing employees for that matter).

It's a balancing act when it comes to employee satisfaction and the employer's bottom line. To attract and retain top talent, employers are under increasing pressure to offer competitive packages while keeping their budgets in line.

So where do ancillary benefits fit into all this?

First, "ancillary" deserves more credit. As the supporting role to the star of employee compensation packages — medical coverage — ancillary benefits often get overlooked, but provide value that spans in both directions: to the employer and employee.

For example, an employer can make lower FICA contributions by taking advantage of Section 125 of the IRS code, therefore keeping costs down while staying competitive in the marketplace. For employees, advantages include an affordable cost since premiums are lower (risk is spread across a large pool) and a way to get preventive care before serious issues arise.

There's no better time to give ancillary benefits more consideration. According to the 2016 Guardian Workplace Benefits Study, perceived value of benefits has declined since 2014. **That directly corresponds with employee job satisfaction and loyalty to their company: 84 percent of employees with high benefits satisfaction report high job satisfaction and 74 percent of employees with high benefits satisfaction want to stay with their current employer for five or more years.**

Ancillary benefits fill the gaps of a limited benefits package, and keep employees healthier and happier, resulting in a more productive workforce. In next month's *CAPsules*, we will review some of the ancillary benefits that you can provide your staff.

Case of the Month

by Gordon Ownby

Court Faults Hospital's Attempt to Use Physician's Orders as Standard of Care

A California appellate court has ruled that an expert's declaration that a hospital followed a physician's orders to monitor two troubled young patients was not enough to establish that the facility met its duty to a patient who claimed he was sexually assaulted by his roommate.

In overturning the hospital's dismissal in *John Doe v. Good Samaritan Hospital* on a motion for summary judgment, the Central California-based appellate court described a high standard of proof for such pretrial motions. (As in many such discussions on appellate cases, the court relied on facts as alleged and assumed true, though not necessarily proven.)

The plaintiff, then 12 years old, alleges that he was sexually assaulted while in the adolescent psychiatric unit of the Bakersfield hospital. His suit claims that the hospital was negligent in placing a 10-year-old boy, admitted under a psychiatric hold for violent behavior, in a room with him. The plaintiff claims that the hospital limited its supervision efforts to observing each patient at 15-minute intervals and that the facility should have conducted one-on-one supervision.

The plaintiff, who was admitted for suicidal and homicidal ideations, was discharged after nine days when he showed improvement. He mentioned no problems during his stay but later exhibited signs of post traumatic stress disorder. Some six months after his discharge, the plaintiff told his parents that his hospital roommate had taken him into the room's bathroom and sodomized him behind a closed door.

The hospital brought a motion for summary judgment, supported by a psychiatric nurse's expert declaration, on the grounds that it did not breach its duty of professional care in any respect or contribute to the plaintiff's injury in any way. The nurse's declaration opined that the hospital met its duties by performing the treating physician's medical recommendations for both patients, including carrying out the physician's order that it observe each patient at 15-minute intervals. The declaration also concluded that one-on-one supervision was not warranted under the circumstances.

The plaintiff failed to qualify any of his witnesses as experts, leaving the hospital's expert declaration unopposed. Based on that lack of opposing expert testimony, the trial court granted judgment in favor of the hospital.

Though the hospital relied on its execution of physician orders for its defense, the treating physician, who testified as a non-expert witness, said he was responsible for medical treatment only, played no role in making room assignments generally, and did not make the room assignments for the two patients.

In overturning the trial court, the Court of Appeal characterized the opinions declared by the hospital's expert as "conclusory" and therefore insufficient to "establish the absence of material fact issue for trial" — the legal threshold for dismissal via summary judgment.

The appellate court noted that though the defense declaration intended to cover all aspects of the hospital's provisions of care and all of plaintiff's theories of liability, "the nurse's declaration is little more than three pages long, does not differentiate between the

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issues, and predominantly contains ultimate facts and conclusions without underlying facts supported by evidence."

"Hospital's expert did not opine specifically or in any detail as to Hospital's applicable protocols and procedures regarding the safety and supervision of those there for treatment," the unanimous three-judge appeals court wrote. "Without any evidence of Hospital's standards and requirements, there is no basis on which to determine the standard of care, the scope of the duty, or conclude that the Hospital complied in this case."

In sending the case back to the trial court judge, the appellate court said the lower court will be required to "determine the nature and scope of Hospital's duties, as well as whether expertise is required to establish applicable standards of care and whether they were breached."

It is a valid question by a physician involved in medical professional liability suit to ask his or her attorney if the judge can "throw the case out" without the need for a jury trial. The *Doe v. Good Samaritan Hospital* case shows the high hurdles the courts can apply to such attempts.

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

Treatment Guidelines Clearinghouse Scheduled to Shut Down

by Gabriela Villanueva

A federal official has expressed hope that healthcare researchers and professionals will continue to have some kind of substitute resource following the scheduled July 16 shutdown of the National Guidelines Clearinghouse. The NGC, a program funded by the Agency for Healthcare Research Quality (AHRQ), boasted a public website offering access to a database drawing an average of 200,000 visitors per month looking for diagnostic and medical treatment guidelines. Everyone from physicians to researchers to academics accessed the NGC to find updated information on the over 4,000 guidelines and documents the repository maintained.

"The Agency knows that many individuals and organizations have built routines and processes around the presence of NGC, so we are exploring a path to sustain NGC or some evolution of NGC and will continue to do so even after the site is offline," said Dr. Francis D. Chesley, Jr., an acting deputy director at AHRQ.

Created by the AHRQ in partnership with the American Medical Association and America's Health Insurance Plans (previously known as the American Association of Health Plans), the NGC provided the documents and guidelines that have become an essential tool for the provision of evidence-based care and therefore part of working routines for those who came to rely on the NGC. Pending news of a replacement resource for the NGC, those looking for guidelines on any particular course of treatment will need to look for the most current guidelines elsewhere, such as guidelines that follow the criteria set by the National Academy of Medicine.

With a decline in funding allocations, the AHRQ's $334 million annual budget is $120 million below its 2010 level and AHRQ allocations to the NGC were omitted for fiscal year 2018.

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

Public Policy

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