THE QUARTERLY PUBLICATION FOR CAP MEMBERS

CAPsules®

COOPERATIVE OF AMERICAN PHYSICIANS

Second Annual CAPtivating Causes Awards to Highlight Members' Community Outreach Efforts

With much of our attention focused on safeguarding citizens during the COVID-19 emergency and on addressing social and racial justice, we are reminded that access to healthcare is a goal not easily achieved. Last year's inaugural CAPtivating Causes gave us all a look into the selfless and creative projects that our members have undertaken worldwide to provide critical medical care to patients who otherwise would have gone without.

In announcing this year's CAPtivating Causes, CAP is especially interested in hearing about what our members are doing in their own local communities to advance health equity among those who do not have access to traditional avenues of medical care.

CAP will present the organization's Community Hero Award to a CAP member whose charitable service merits special recognition. The award will include a $5,000 grant for the charitable organization affiliated with the physician's work. One runner-up will receive the Community Leadership Award, which will include a $1,000 grant for the recipient's associated charity.

If you are interested in celebrating the work of a fellow CAP member who has made significant contributions to a charitable cause here at home by offering his or her time, talents, leadership, and service, you may submit your nomination to Communications@CAPphysicians.com. Self-nominations are welcome.

Nominations must include:

- Name of physician
- Statement summarizing charitable service

The deadline for nominations is August 30, 2020. CAP membership is required to qualify as a nominee. If there is a physician you would like to refer for membership, please contact Membership Development at 800-356-5672 or MD@CAPphysicians.com.

After a thorough vetting and selection process conducted by CAP staff and the CAP Membership Education and Engagement Committee, as well as approval by CAP's Board of Directors and MPT Board of Trustees, selections will be announced in November 2020. Award payments will be issued no later than January 2021.

Risk Management and Patient Safety News

Focused Review: A Look Into Urgent Care

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

Urgent Care Centers (UCC) fill a much-needed gap in an overwhelmed healthcare system. According to the Urgent Care Association (UCA), there has been steady growth in the number of UCCs operating in the United States over the last 10 years. In 2013, there were a total of 6,100 nationwide. That number is now approaching 10,000. The physicians practicing in these centers, like emergency medicine and family medicine practitioners, need a broad knowledge base and skill set that enables them to quickly assess and identify acute problems as well as unknown chronic conditions that may present as a benign common symptom.

Because of the wide range of clinical issues UCCs encounter on a regular basis, seemingly routine care processes have the potential to pose serious risks to patients, leaving physicians vulnerable to medical professional liability.

In the latest focused review, the risk management and patient safety experts with the Cooperative of American Physicians, Inc. identified five common areas of liability risk associated with claims against UC physicians. Cognitive bias, supervision of advanced practice professionals, documentation, repeat visits with the same complaint, and patient referrals and transfers to higher levels of care are among the issues reviewed, along with supporting case studies. Effective and actionable risk reduction strategies are also provided for each area.

As UCCs continue to expand their presence in the healthcare market and evolve their services, a greater awareness and understanding of the risks associated


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Risk Management & Patient Safety
Focused Review

A Look into Urgent Care

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In this Focused Review . . .

The risk management and patient safety experts with the Cooperative of American Physicians, Inc. (CAP) identify five common areas of liability risk associated with claims against Urgent Care (UC) physicians. Cognitive bias, supervision of Advanced Practice Professionals (APP), documentation, repeat visits with the same complaint, and patient referrals and transfers to higher levels of care are among the issues reviewed, along with supporting case studies. Effective and actionable risk reduction strategies are also provided for each area.

As Urgent Care Centers (UCC) continue to expand their presence in the healthcare market and evolve their services, a greater awareness and understanding of the risks associated with the practice of UC medicine by physicians of all specialties and backgrounds will play a crucial role in ensuring the implementation of essential patient safety measures in urgent care center settings, and across the continuum of care.

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Risk Issue: Cognitive Bias

UC specialists are trained to recognize, interpret and balance a multitude of data when treating patients. The hope is that their training will help them avoid scenarios that lead to misdiagnoses, patient harm, and potential claims.

Cognitive bias is manifested in many ways and can lead to devastating missed or delayed diagnoses. Bias occurs when practitioners tend to interpret the information gained during a consultation to fit their preconceived diagnosis, rather than the converse. For example, suspecting the patient has an infection and the raised white cells proves this, rather than asking, "I wonder why the white cells are raised, what other findings are there?" Cognitive bias can result in a diagnostic error, which is an issue seen in CAP's UCC claims.

Case Study A 60-year-old man, Mr. J, presented to a UCC in the middle of cold and flu season. He complained of a cough and increasing fatigue for a week. The physical exam revealed both rales and rhonchi over the right lung, along with crackles over the left. Mr. J was awake and alert, and his vital signs were 119/59, pulse 102, respiratory rate 18, and temperature of 98.3. His O2 saturation was 96% on room air. He had a history of Insulin-Dependent Diabetes Mellitus (IDDM). Mr. J was diagnosed with acute bronchitis and was prescribed an antibiotic and cough medicine.

A few hours after he returned home, Mr. J was found unresponsive by his wife; paramedics were called and upon arrival they found Mr. J in asystole. CPR was begun and Mr. J was transported to a hospital where his blood sugar was over 1200 mg/dl. Unfortunately, Mr. J arrested several times over the next two days resulting in an anoxic brain injury. He died two days following the UCC visit. The cause of death was determined to be diabetic ketoacidosis and severe hyperkalemia.

In this example, the treating physician's bias failed to consider any other differential diagnosis. Since it was the cold and flu season, bronchitis was assumed to be the diagnosis.

Strategies to Consider

1. Always consider alternative diagnoses, especially when you have decided or arrived at a diagnosis quickly.
2. Consult with a colleague. They may see or consider something that you missed or misinterpreted.
3. Create a list of differential diagnoses and as test results return, eliminate those that are ruled out. Show your thought process to demonstrate that the standard of care was met.
4. Actively try to invalidate your belief by looking for evidence that opposes it.
5. While factors like fatigue, frequent interruptions, and feeling rushed are sometimes unavoidable in a busy setting, knowing that they play a role in cognitive bias can help you recognize when they are affecting your decision making.

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with the practice of UC medicine by physicians of all specialties and backgrounds will play a crucial role in ensuring the implementation of essential patient safety measures in urgent care center settings and across the continuum of care.

The *Risk Management and Patient Safety Focused Review: A Look into Urgent* Care can be downloaded at www.CAPphysicians.com/reviews.

CAP's priority is to support its members with specialty-specific education around risk and patient safety issues that can impact your career with the goal of reducing your liability, protecting your patients, and helping you succeed in practice.

While the risks emphasized in this focused review are not inclusive of all the potential areas of liability that a UC physician may face, it does bring to light the common allegations and contributing factors that are seen most often in claims.

CAP members may seek assistance if a situation arises that calls for guidance on how best to handle an adverse event or outcome, reduce exposure, or manage the risks involved via the Risk Management Hotline at 800-252-0555. Experienced risk managers are available to members 24/7 to provide guidance and answer questions.

Questions or comments about the focused review may be sent to riskmanagement@CAPphysicians.com.

Health Insurance **During the COVID-19 Pandemic**

Many insurance carriers are providing additional services to their members during this challenging time. Please feel free to contact our benefits insurance broker partner, Ashbrook-Clevidence, if you would like assistance in managing your health insurance plans during the COVID-19 pandemic.

Medical Insurance

Whether it be covering the cost of COVID-19 tests and treatment, or the benefits already available that make managing healthcare more accessible, insurance carriers have a number of resources to offer during this time.

Telemedicine, a way to virtually visit with your primary care physician or specialist, has been available to members for many years, but you may not know that most insurance carriers have reduced the copay for telemedicine visits to $0 during the COVID-19 pandemic. Teladoc, a virtual or phone visit with one of Teladoc's providers, is the most popular virtual provider network used by insurance carriers and is offering $0 copay visits for members within partnered carriers.

If you're on a PPO medical plan or the Blue Shield Trio HMO plan, you may have access to a home visit from a healthcare provider through Heal. If you would like to find out more about how to see the doctor during this time, contact Ashbrook-Clevidence, Inc.

The IRS recently released guidance regarding Health Savings Account (HSA) eligibility when participating in a high deductible health plan (HDHP). COVID-19 related testing and treatment is not subject to the deductible and will be treated as "first dollar coverage." If you are on an HDHP, you are still eligible to make HSA contributions even if your carrier opted to cover COVID-19 tests and treatment.

If you or a loved one is struggling during the COVID-19 pandemic, many carriers offer Employee Assistance Programs (EAP). Oscar and United Healthcare offer services via Optum, a toll-free emotional support helpline staffed by professionally trained mental health experts. The service is free of charge and available to anyone, whether they are members or not. You may share the information with anyone that needs this assistance.

Are you and your loved ones in need of insurance coverage? Or did you previously waive coverage? Most insurance carriers are offering special enrollment opportunities with COVID-19 being considered a qualifying event. This applies to both group business plans and individual and family plans.

Some employers have been forced into temporary layoffs, furloughs, or reduction of employee hours during this time. Many carriers are allowing benefits to continue, but it is important to offer this to all employees to remain compliant with regulations.

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When employees are rehired, many carriers are offering waivers of waiting periods for those rejoining the plan to help members start coverage sooner. Carriers are also offering deductible credits for those rehired employees so that they do not have to meet their deductibles once they return to work.

There are also prescription drug opportunities for individuals who have lost coverage and need assistance paying for their prescriptions. GoodRx or Parachute Rx by Express-Scripts are a great resource for savings and discount programs.

If you are looking to change medical benefits but it is not your regular annual open enrollment time, insurance carriers are allowing off-anniversary plan changes due to the COVID-19 qualifying events.

Dental Insurance

Going to the dentist may be more difficult during this time, but did you know you may have access to teledentistry visits during the COVID-19 pandemic?

Many dentists are following guidelines to postpone non-essential dental health visits, so it is important to check with your dentist to see what services he or she is performing. Because of this, virtual visits with a dentist do not count against your annual frequency for most carriers during this time.

If your dental insurance is through MetLife, your April and May premiums are being discounted 25 percent in the form of a credit towards a future bill to help clients with finances during this challenging time.

Vision Insurance

While the Centers for Disease Control and Prevention (CDC) has recommended postponing non-essential vision care services, member need for benefits do not stop.

Many online eyewear retailers offer alternative solutions to getting glasses and contacts while your vision provider might be closed during this time.

Vision Service Plan (VSP) is offering a savings program to those without vision coverage to assist those who cannot afford coverage.

VSP is also offering essential vision benefits to all members during this time, regardless of their current plan benefits at VSP. Essential care includes, but is not limited to, sudden vision changes or loss, eye trauma, pink eye, foreign body removal, and other symptoms that hamper day-to-day activities.

Other FAQs Around COVID-19

While we do not provide legal guidance, we do have HR consultants as well as resource documents to help with any questions regarding the Paycheck Protection Program, CARES Act, and other legislation surrounding COVID-19 or questions you may have regarding compliance.

Please contact our broker partners at Ashbrook-Clevidence for additional information on how to best manage your healthcare or to learn about resources available to you at 800-447-4023 and ask for Evan Bruski or Cristina Burnell. Or you may send them an email at EvanB@aclevidence.com or CristinaB@aclevidence.com, respectively. The website address is www.aclevidence.com.

Final Guidelines Announced for Full Implementation of CURES 2.0

by Gabriela Villanueva

Public Policy

California is one of 39 states that mandate physicians and other authorized prescribers check their statewide prescription and drug monitoring databases. In 2016, California passed SB 482, requiring physicians to check the Controlled Substances Utilization Review and Evaluation System — better known as CURES — before prescribing opioids and other controlled substances to a patient for the first time. The law also requires the authorized prescriber to check the CURES database at least once every four months while the drug remains part of the treatment.

The California Department of Justice maintains the CURES database and, under a provision of SB 482, required the department to certify the database before requiring prescribers to comply with its use. Since then, there has been a series of delays for certification including improving the system's capacity, the hiring of more personnel to efficiently run the system, and the department's requirement under AB 1751, enacted January 1, 2019, to adopt regulations by July 1, 2020 involving the access and use of information within CURES. This final step has now been completed.

After the department released proposed regulations in October 2019 for its database access and use, the department received comments from the public, including from two public hearings held in November 2019. It was followed by the department releasing revised regulations on January 16, 2020 while also seeking additional comments. On June 1, 2020, the department announced its final CURES regulations to become effective as of July 1, 2020.

Final regulations outline the process for approving, denying, and disapproving individuals or entities seeking access to information in CURES, with the purpose to:

- Assist healthcare practitioners, including pharmacists, in appropriate prescribing, ordering, administering, furnishing, and dispensing of controlled substances;
- Assist law enforcement and regulatory agencies in their efforts to control the diversions and consequent abuse of Schedule II, III, and IV controlled substances by outlining the conditions under which a warrant, subpoena, or court order is required for law enforcement agencies to obtain information from CURES as part of a criminal investigation; and
- Assist the access to CURES database information for statistical analysis, research, educational, and peer review functions.

For more details, view the CURES Regulation Fact Sheet:

https://oag.ca.gov/sites/all/files/agweb/pdfs/jdis/cures-updated-info-digest.pdf

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

Ask My Practice

by Andie Tena

Question: I have five staff members in my medical practice and I read somewhere that California now requires sexual harassment prevention training for employees. Does my office need to meet this requirement or does this not apply to small businesses?

Answer: The short answer is yes, your office does need to comply with this requirement. California employers with five or more employees are required to provide sexual harassment prevention training to all employees by January 1, 2021. CAP recommends that your practice train your employees now and not wait until the end of 2020.

On August 30, 2019, California Governor Gavin Newsom signed SB 778 into law, which extended the training deadline from January 1, 2020 to January 1, 2021. All employees who have been hired or employees who have been promoted to supervisor positions since September 2018 must be trained within six months of hire or promotion. SB 778 does not change this requirement.

Did you know that CAP offers **free online** courses that fulfill this requirement? As part of your membership, you receive access to courses for both supervisory and non-supervisory employees through Kantola Training Solutions. You and your staff may access these courses by completing the form on CAPphysicians.com/hrtraining.

If you have questions regarding any HR issues, please 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.

Andie Tena is CAP's Director of Practice Management Services. Questions or comments should be directed to **atena@CAPphysicians.com.**

Case of the Month

by Gordon Ownby

Plaintiff Experts Need to Connect the Dots on Causation

Virtually all medical malpractice cases turn on expert testimony. If the conflicting testimony by the expert witnesses called by the plaintiff and the defendant meets proper thresholds, a jury will be called on to decide which expert to believe. But even a well-qualified physician cannot utter just any words to get a case to the jury.

A plaintiff must prove four prongs to prosecute a claim of medical professional liability: That a duty existed between the defendant healthcare provider and patient; that the healthcare provider was negligent in his or her treatment of a patient; that the patient suffered an injury; and that there was a causal link between that injury and the negligence. The duty and injury components are usually easily met, leaving the bulk of cases to be fought over as a battle between experts. But the last requirement, "causation," can sometimes trip up a plaintiff's case.

A 57-year-old gentleman drove to the hospital emergency department at 4:03 a.m. complaining of stomach pain and a tight chest. Within 15 minutes, vital signs were recorded, including a pain level of 7 out of 10. A nurse noted the patient's height and weight (including a Body Mass Index of 33.9) and that he complained of neck pain, cough, sore throat, and chest congestion "'like a dull ache in my throat, like I'm getting strangled below my neck.'" The nurse noted the patient was alert, was denying any chest pain or shortness of breath, was speaking normally, and ambulating without difficulty. After triage, he was placed in a bed at 4:22 a.m.

The patient was then evaluated by another nurse and her notes recorded at 4:59 a.m. reflected the patient was alert, oriented, cooperative, appeared to be in distress from pain, and that he had woken up with pain as if something was "stuck" in his throat. The notes reflect that the patient complained of epigastric pain, that he denied shortness of breath or inability to swallow but that he said he feels the needs to "clear his throat, but when he does, it doesn't clear." The nurse noted no respiratory distress but upper chest pain and a sore throat. At 5:03 a.m., the patient was placed on a cardiac monitor and notes at 5:46 a.m. show that an IV site had been established and drawn specimens sent to the lab.

Dr. ER1, an emergency specialist, evaluated the patient at 5:10 a.m. and ordered an electrocardiogram, which he reviewed at 5:34 a.m. A radiologist read a chest x-ray ordered by Dr. ER1 as showing "no radiographic evidence of acute cardiopulmonary disease" but "mild cardiomegaly."

Another nurse took over the patient's nursing care at 6:19 a.m. and notes of that care showed vital signs and that the patient "standing at bedside for comfort."

Dr. ER2 took over from Dr. ER1 at around 6:00 a.m. and records show that over the next several hours, various tests were performed, including another ECG, two troponin tests, and other blood work. In his testimony later, Dr. ER2 said that though he had no independent memory of treating the patient, it was his custom and practice to look at electronic records to see if a patient had been treated at the hospital previously. Also, according to his custom and practice, he would have looked at any previous discharge summaries and old

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ECGs, and would have talked to the patient.

At 11:00 a.m., Dr. ER2 decided to discharge the patient after seeing him a second time and "improved." Serial vital signs throughout the morning were normal and stable, and the patient's pain had reduced to 4 out of 10. Dr. ER2's discharge included a diagnosis of "chest pain of unclear etiology," a referral of the patient to a cardiologist, and instruction to follow up with his primary care physician in one day.

Less than eight hours after discharge, the patient died of an acute dissection of the aorta.

Among the various allegations brought by the patient's family in its lawsuit was the accusation against the hospital that had the nurses reviewed the patient's chart from a hernia repair at the hospital the previous year (which included a history of smoking, morbid obesity, heart murmur, high blood pressure, and high cholesterol), notation of that review would have set in motion a chain of events that would have prevented the patient's death.

In fact, in opposing the hospital's motion for summary judgment (which was supported by expert testimony stating that hospital staff met the standard of care in all respects), the plaintiff produced a declaration by an expert in emergency room medicine critical of the nursing staff. In that declaration, the expert noted nursing notes stating, "History provided by patient. No past medical history."

In the expert's opinion, had the nurses obtained the patient's medical history from the chart, a reasonably prudent emergency physician would have summoned a cardiologist for an emergency consult, the cardiologist would have ordered a CT scan with IV contrast, the CT scan would have shown the cause of the patient's chest pain was an aortic dissection, and the cardiologist and ER physician would have arranged for a cardiothoracic surgery consult. The expert continued that if no surgeon was at the facility, the patient would have been transferred to another facility and the patient "would have received timely diagnosis and treatment." A plaintiff expert in cardiology further opined that "more likely than not, a CT scan with IV contrast of the chest would have shown that the cause of [the patient's] chest pain was thoracic aortic dissection" and that had a cardiologist have been called, surgery would have been performed and the patient would have survived.

The defense objected to the declarations on grounds of speculation, conjecture, and failure to state causation to a reasonable medical probability.

The trial court judge's grant of the defendant's motion for summary judgment was upheld by the Court of Appeal in *Wicks v. Antelope Valley Healthcare District*. In ruling that neither declaration created "a material disputed fact" that the nurses' performance caused or contributed to the patient's death, the appellate court wrote that the plaintiff's ER expert's declaration "completely ignored" the testimony of both ER doctors that they themselves customarily reviewed a patient's medical history.

In finding in favor of the hospital, the appellate court noted that the evidence was undisputed that nurses took and recorded the patient's vital signs multiple times and noted his mass index indicating obesity. The court also noted the patient's placement on a cardiac monitor and had lab specimens drawn.

"[The ER expert] offers no explanation why nurses' notes summarizing past records of cardiac risk factors would have helped the ER doctors understand anything about [the patient's] cardiac conditions that they did not already know from his vital signs, ECGs, chest X-rays' and troponin tests."

The court of appeal said that the ER expert's "opinions rest not on facts but a series of hypothetical conditions," which could not meet the plaintiff's burden.

"An expert's opinion rendered without a reasoned explanation why the underlying facts lead to the ultimate conclusion has no evidentiary value because an expert opinion is worth no more than the reasons and facts on which it is based."

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

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We welcome your comments! Please submit to communications@CAPphysicians.com.

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