THE MONTHLY PUBLICATION FOR CAP MEMBERS

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COOPERATIVE OF AMERICAN PHYSICIANS

Interview with Sarah E. Scher, CAP CEO

The Cooperative of American Physicians, Inc. (CAP) is a leading provider of medical malpractice coverage, risk management, and practice management services for California physicians. Meet Sarah E. Scher, Chief Executive Officer of CAP. Physician Today *spoke with her recently to find out more about why an organization like CAP can be such a huge benefit to the state's physicians, especially now during these uncertain times.*

***Physician Today*:** Your organization is a cooperative that provides medical professional liability coverage and other services to physicians and medical practices. Why is a cooperative better for protecting and supporting physicians than an insurance company?

Sarah: The Cooperative of American Physicians was established in 1975. Our customers are members. We are uniquely positioned to be a partner in their businesses. In 1977, CAP formed the Mutual Protection Trust (MPT) to provide medical malpractice protection to healthcare providers. MPT today protects some 12,000 California physicians.

We do not operate with a profit motive. Our intent is to protect and bolster the success of our members' medical practices. We do not answer to investors; instead we answer to our physician members because we are physician owned and governed. Our CAP Board of Directors and MPT Board of Trustees are composed entirely of practicing physicians who recognize the unique challenges faced by healthcare providers. They hold the executive team accountable for identifying and creating solutions that permit our members to focus on patient care.

***Physician Today*:** That sounds like a unique approach for providing coverage to physicians, but how have you been able to deliver substantial cost savings year after year?

Sarah: Unlike a traditional insurance company, MPT assesses its members for the overall amount that is anticipated necessary to pay medical malpractice claims and administrative expenses over the next 12 months. This has typically made MPT and CAP more affordable, consistent, and stable than most insurance carriers. MPT's sustained A.M. Best A+ Superior rating is proof of this.

This year, MPT utilized its unique structure and capacity to refund assessments to members in response to the COVID-19 pandemic. We recognized our members' needs and offered not only a timely refund, but also payment

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deferrals, assistance with how to apply for a CARES Act loan, and risk management, practice management, and telemedicine support throughout the crisis.

***Physician Today*:** How has COVID-19 affected your business? What are you doing to ensure your members' success during COVID-19?

Sarah: As a physician-based organization, we have a closer and more collaborative relationship with our members than a commercial insurance company might. Because of this, we were able to quickly learn, in real time, the kinds of challenges our members were facing. Some we expected, but others seemed counterintuitive. For example, we initially thought many of the practices would be overrun with sick patients. But once social distancing was broadly enacted, we learned that our members were facing massive reductions in revenue due to cancelled and delayed appointments and procedures.

That's why we quickly launched our COVID-19 Resource Center to help physicians keep up to date on the legislative and regulatory responses from state and federal officials. We are helping them manage the unique risks and patient safety challenges to stay ahead of the curve on treatment — especially relating to telemedicine and proper coding/billing — and to maximize the small business support and financing of the CARES Act.

We continue to assist members individually when they contact us for guidance. But given the scale of this crisis, we've been proactive, reaching out to our members through regular information updates and webinars to answer questions about all sorts of business issues, including closing and reopening their offices. The CAP Risk Management, Practice Management, and Human Resources hotlines have been very busy.

And as I mentioned before, we quickly issued an assessment refund to members in April that we hope helps them however they've been affected by the crisis.

***Physician Today*:** What is CAP doing to help the physician community at large during the crisis?

Sarah: First, we have opened up our COVID-19 Resource Center and webinars to all physicians, medical staff, and practice managers who wish to tune in, free of charge. And the response has been tremendous. We've had hundreds of non-CAP physicians join our webinars and visit the Resource Center, because they know of our reputation for providing valuable, actionable guidance to our members.

The most common concern we are hearing from physicians is the loss in revenue caused by the shutdown and the resulting need to reduce overhead expenses. This is where CAP's time-tested business model of delivering coverage, at cost, has proven itself so valuable. We have already helped many physicians lower their costs for malpractice coverage by switching to CAP during the crisis. And they are saving thousands more through our enhanced services like the CAP Purchasing Alliance, a free group purchasing organization formed to help CAP members save on virtually everything they purchase for their practices.

***Physician Today*:** How has COVID-19 affected CAP's staff members and business operations?

Sarah: In addition to attracting California's best physicians, CAP is also known for cultivating an exceptional team of staff members who continually strive for excellence in their work, much like our members do in their own practices. In less than one week, the company was able to migrate from a mostly office-based organization to a 100 percent work-at-home environment. CAP staff are fully engaged, productive, and accessible to our members by phone, email, and online. Having a dedicated team of seasoned professionals is one of CAP's greatest assets. It allows us to be very nimble to accommodate the rapidly evolving situation. As the progression of the COVID-19 crisis dictates, CAP will carefully plan and execute its return to an office-based environment while still maintaining a productive remote working component.

To read the complete interview, please visit **https://www.capphysicians.com/media-appearances/physician-today-conversation-cap-ceo-sarah-e-scher**

Risk Management and Patient Safety News

Think About Patient Safety When Reopening Your Medical Practice

by CAP's Risk Management and Patient Safety Team

As patients resume scheduling their routine medical appointments during the COVID-19 pandemic, vigilance is required to protect them from infection and to reduce the risk of potential COVID-related litigation. The following is a sample list of risk reduction strategies to ensure your patients' safety. For more comprehensive information and risk reduction strategies on each subject, please follow the links below for resources featured on CAP's website from the California Medical Association (CMA), the American Academy of Family Practitioners (AAFP), the Medical Group Management Association (MGMA), and more.

Office Visit Versus Telemedicine Visit

- Continue telemedicine encounters for routine patient visits that do not require physical examination.
- Prioritize and reserve office visits for high-risk patients, such as the elderly and those with chronic conditions, and those that require a physical exam.

Learn more:

CAP's COVID-19 Resource Center **www.CAPphysicians.com/articles/cap-covid-19-resource-center**

MGMA Practice Reopening Checklist **www.mgma.com/MGMA/media/files/pdf/MGMA-Practice-Reopening-Checklist.pdf?ext=.pdf**

Physical Distancing

- Provide two separate entrances: one for well patients and the other for sick patients.
- If separate waiting rooms are not available for well and sick patients, instruct them to call your office upon arrival, and have them wait in their cars or outside until it is time for their appointment.
- Have your patient bring one family member only, when necessary.
- Always keep exam room doors closed during visits.

Learn More:

CMA Guidelines for Reopening **www.CAPphysicians.com/sites/default/files/CMA-COVID-19-Guidelines-for-Reopening.pdf**

Infection Control

- Assess your patient via telephone the day before appointment for symptoms of illness. Encourage a telehealth visit, when applicable.
- Require patients and their family members to wear facial masks. If they do not have one, provide them with a disposable facial mask.
- Assess patients for illness, including temperature checks, before the patient enters the building or medical office.

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- Implement isolation precautions for those exhibiting signs of illness and disinfect exam room after each patient visit.
- Provide appropriate personal protective equipment to staff and require its proper use. Maintain adequate inventory as much as possible should shortages continue.
- Mandate handwashing and universal precautions.

Learn More:

AAFP Office Prep Checklist, CDC Guide to Disinfecting Your Facility **www.CAPphysicians.com/sites/default/files/AAFP-COVID-19-Office-Prep-Checklist.pdf**

Physician/Staff

- Establish a temperature check and symptom monitoring policy for staff.
- If a staff person is ill, encourage him/her to stay home. If the staff person tests positive for COVID-19, follow CDC guidelines for isolation.
- If a provider tests positive, implement steps for a potential office closure, including patient notification, and notification among high-risk patients for continuity of care, etc.
- Communicate with your staff daily and make sure everyone understands procedures.
- Call CAP's Hotline at 800-252-0555 to speak with a Risk Manager and/or Human Resources Specialist.

Learn More:

OSHA Guidance on Preparing Workplaces for COVID-19 **www.CAPphysicians.com/sites/default/files/OSHA3990-Guidance-on-Preparing-Workplaces.pdf**

Medical experts predict that COVID-19 will have a second surge as "Safe at Home" orders and other governmental restrictions are eased. CAP recommends that you stay informed by consulting local, regional, and state governmental and health agencies; and be prepared for another possible office closure.

California Workers' Compensation Benefits for COVID-19?

Historically, communicable diseases, such as the flu, have generally not been covered by workers' compensation insurance. Workers can file a workers' compensation claim alleging COVID-19 contraction or exposure, but until the recent Executive Order N-62-20 signed by Governor Gavin Newsom, they would have to show that they contracted the disease while they were on the job. Workers' compensation benefits apply to an injury or illness that meets the: "Arise out of or in the Course of Employment." Workers' who are injured on the job receive indemnity benefits and medical treatment with no copayments or deductibles.

Labor and Business Leaders in California were aggressively lobbying Governor Newsom's office over the sweeping change the administration was considering to the state workers' compensation system. "Many businesses and their owners are casualties of the necessary economic shutdown," wrote California Chamber of Commerce President Allan Zaremberg to Newsom and his staff in a letter dated April 7. "They cannot be expected to shoulder a new employer-financed social safety net, with expensive new mandates, at precisely the moment when small businesses are shuttering, employee hours are cut, and uncertainty about the future is the new normal".

On May 6, 2020 Governor Gavin Newsom did indeed sign Executive Order N-62-20 **www.gov.ca.gov/wp-content/uploads/2020/05/5.6.20-EO-N-62-20-text.pdf**. In summary, the order identifies requirements to establish whether an employee who contracts COVID–19 is eligible for workers' compensation benefits.

Any COVID–19-related illness of an employee shall be presumed to arise out of and in the course of the employment for purposes of awarding workers' compensation benefits if all the following requirements are satisfied:

• The employee tested positive or was diagnosed with COVID-19 within 14 days after a day they performed services at the employee's place of employment at the employer's direction

• The day the employee worked at their place of employment at the employer's request was after March 19, 2020

• The employee's place of employment described above was not in the employees' home or residence

• The diagnosis of COVID–19 was done by a physician who holds a physician and surgeon license issued by the California Medical Board and that diagnosis is confirmed by further testing within 30 days of the date of diagnosis.

This presumption is disputable and may be controverted by the employer, but unless it is controverted, the Workers' Compensation Appeals Board is bound to accept the workers' compensation claim. This presumption shall only apply to dates of injury or illness occurring through 60 days following the date of this Order or July 6, 2020. A claim of COVID–19 related illness must be rejected by the employer and insurance carrier within 30 days after the date the claim form is filed. Employees with COVID–19 can collect temporary disability after they have exhausted all of their paid sick leave.

The California Workers' Compensation Insurance Rating Board (WCIRB) estimates such a shift could cost employers between $2.2 billion and $33.6 billion per year with an approximate mid-range estimate of $11.2 billion or 61 percent of the annual estimate cost of the total workers' compensation system prior to the impact of COVID–19.

The healthcare industry has been financially impacted by COVID–19 that may also be impacted by changes in the presumption this Order will provide by greatly impacting their premium cost for workers' compensation.

Here at CAP Agency, we strive to get you the best coverage at the lowest premiums. This is why we work with insurance carriers that care about their insureds. We are in constant contact with the carriers we use to be informed of what they are doing to help their customers. If you are struggling during this time of disruption, please call us. We will reach out to our carriers to get you the help you need on all of your insurance you have with our Agency. You can call or email us at 800-819-0061 or CAPAgency@CAPphysicians.com.

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Telemedicine Makes Its Mark in 2020

by Gabriela Villanueva

In response to the emerging threat of the COVID-19 virus, both President Trump and Alex Azar, Secretary of Health and Human Services (HHS), made national health emergency declarations at the end of January. These actions automatically and collectively allowed the federal government to activate resources to assist state and local governments in their attempts to reduce the spread of the virus and mitigate economic losses. Under these declarations, additional statutory authorities were also triggered.

Increased use of telemedicine soon followed.

With the health emergency declared, on March 17th Secretary Azar proceeded to issue multiple waivers under his authority of the Centers for Medicaid and Medicare Services (CMS) to quickly expand access to and use of telehealth services for Medicare recipients. Waivers expanded coverage while also waiving HIPAA penalties for "good faith" use of telehealth during the current emergency. The urgency the health crisis has presented to keep individuals in their homes has given way to an almost frenzied use of telehealth services since it offers a unique capacity for remote screening, triage, monitoring, and treatment, and has shown to be a powerful tool for reducing the transmission of the novel coronavirus to and among healthcare workers and those not infected.

CMS continued to release waivers providing flexibilities that have now become very popular with both patients and providers. Patients can be seen while sitting in their homes with "visits" conducted through FaceTime, Skype, or other commonly used video conferencing apps and platforms (in California, public-facing apps such as Facebook Live cannot be used). Recognizing that older patients may not commonly use these technologies, a later waiver allowed for telephone consultations to be paid at the higher rate of an in-person visit. Another big change has been the allowance of expanding telehealth to new patients without the original requirement of having to be seen first in the office. Clearly, the technology is helping to fill the gap in care created by the health emergency but a major contributor to practices now being able to so quickly implement telehealth is quite likely the official pull back from very restrictive regulations.

Commercial insurers have also followed suit and expanded their own telehealth coverages and paid services, helping to strengthen revenue sources for the many practices that saw a huge dive in physical visits and with it, decreased revenues.

Providers have made very good use of the waivers to establish and increase the use of telemedicine in their practices, allowing them to remain connected to their patients and keeping their "virtual" doors open. Telemedicine and virtual care by thousands of medical practices across the country not only quickly became a critical way of delivering patient care in this pandemic, but is helping to mitigate the harsh economic blow by keeping physician practices afloat during a public health emergency that has turned into a global financial crisis.

These waivers will remain in place through the duration of the emergency health declaration. With the strong likelihood of "a second wave" of this pandemic and the clear warnings by health authorities of a compounded impact during the upcoming flu season, telemedicine will continue its vital role in the delivery of care for the foreseeable future . . . and beyond.

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

Case of the Month

by Gordon Ownby

Plaintiff Gets Leeway in Timing of Suit Against Subsequent Treater

Determining when a plaintiff must act to sue a healthcare provider is a topic of longstanding interest in California's courts. A new case adds a twist: Does a patient suing a subsequent treating physician get additional time to sue?

On April 22, 2013, Judith Brewer underwent carpal tunnel and shoulder surgery. Early the next morning, she became paralyzed and sought emergency treatment from Benjamin Remington, MD, a neurological surgeon. Tests revealed Ms. Brewer suffered spinal cord syndrome, cervical spine stenosis, paraplegia, and incontinence. According to the allegations relied on in the Court of Appeal opinion, Dr. Remington performed spinal compression surgery on Ms. Brewer on May 30, 2013, after waiting for a reduction in the patient's swelling. After the surgery, the patient allegedly regained some movement in her arms and legs but did not fully recover.

Judith and Michael Brewer filed a medical professional liability lawsuit against Brewer's original surgeon, the anesthesiologist, the hospital, medical clinic, and "Doe" defendants within the statute of limitations period under the Medical Injury Compensation Reform Act (MICRA). "John" or "Jane Doe" defendants are intended to allow a plaintiff to add codefendants to a suit once their identities become known.

As the case proceeded, the plaintiffs obtained medical records and had those records reviewed by a medical consultant. On July 20, 2015, Brewer's expert, a neurological surgeon, opined that Dr. Remington breached the standard of care by not immediately commencing with surgery to decompress Brewer's spine. According to the expert, Dr. Remington's delay was a significant factor in causing her ongoing neurological deficits.

After receiving the report, the plaintiffs filed a "Doe amendment" on July 24, 2015, filling in Dr. Remington's name as a new codefendant in the ongoing lawsuit. Dr. Remington filed a motion for summary judgment in the trial court, claiming that the lawsuit was barred by the one-year statute of limitations. In his motion for a dismissal, Dr. Remington argued that Ms. Brewer knew his identity and all of the facts giving rise to the claims against him by April 23, 3013, and certainly by May 30, 2013, when he performed the spinal decompression surgery.

The Brewers argued that Dr. Remington was added as a defendant as soon at they learned that his (alleged) failure to immediately perform the spinal decompression surgery may have precluded Ms. Brewer from recovering more of her abilities and caused her to injury to become permanent.

Importantly, plaintiffs argued that the nature of Dr. Remington's alleged negligence provided no basis for Brewer or her counsel to suspect Dr. Remington had breached the standard of care and contributed to the plaintiff's neurological injury.

The California law in question is Section 340.5 of the Code of Civil Procedure, which imposes a one-year limit to bring a lawsuit against a healthcare practitioner when a plaintiff suspects or has reason to suspect that her injury was caused by wrongdoing. The Brewers' argument is that prior to getting an expert opinion, Ms. Brewer and her counsel had no

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suspicion of wrongdoing by Dr. Remington. Once they received the expert's report, they added Dr. Remington's name immediately.

Dr. Remington in turn argued that it is the suspicion that *someone* was negligent that commences the statute of limitations and triggers the plaintiff's duty to investigate — not when the plaintiff discovered precisely *how* a defendant was negligent.

In considering the motion for summary judgment, the judge at the trial court level said that whether Ms. Brewer should or should not have suspected negligence prior to getting the expert opinion is a factual issue (which cannot be decided by a judge via summary judgment) and not a legal issue (which can). When the case reached the Central California Court of Appeal in *Brewer v. Benjamin Remington*, the appellate court explained how the courts view such a distinction: "[W]henever reasonable minds can draw only one conclusion from the evidence, the question becomes one of law." But because there could be more than one reasonable conclusion on the plaintiff not suspecting within a year of his treatment that Dr. Remington caused her injury, the Court of Appeal supported the trial court's determination that there were factual issues to be decided.

"Remington argues Judith's statue-commencing injury was her paralysis and loss of sensation during and after his medical care, which was apparent and appreciable throughout his treatment of her as well as after the spinal decompression surgery. Plaintiffs argue Judith suffered a second injury by Remington's delay of the spinal injury, and it is a factual issue whether there was any appreciable harm plaintiffs should have discovered prior to July 2015 from which they reasonably should have suspected Remington had done something wrong. We agree with plaintiffs."

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

Risk Assessment Peer Review Committee: Physician Openings for Committee Participation

CAP prides itself on being a physician-owned and governed organization. Vital to the organization is the instrumental role physician members play by participating on a variety of committees.

The purpose of Risk Assessment Peer Review Program (RAPR) is to evaluate the continued and future risk sharing of any physician member of MPT identified with a potential unfavorable affecting risk exposure.

Any MPT member in good standing may be appointed to serve on a Risk Assessment Peer Review Committee. Committee members are compensated for their review of materials and their attendance at the meeting.

A Risk Assessment Peer Review Committee meeting is intended to be a physician-to-physician, member-to-member discussion that will assist the Committee in evaluating the member invitee's professional qualifications, clinical knowledge, practice skills, judgment, and actual or potential risk to MPT.

If you've ever wondered what participating on a CAP Committee entails, you may be surprised. You'll meet smart, dedicated physicians just like you who care about making CAP, and the protection it provides to physicians, the very best it can be.

Please contact **Kimberly Danebrock** at **KDanebrock@CAPphysicians.com** for more information.

Question: How do I let my patients know that our practice now offers the option of telemedicine visits? What can I do to ensure that my patients receive the same level of care with telemedicine visits as they do with in-office visits?

Answer: The Centers for Medicare and Medicaid Services (CMS) wants practices to let patients know that telemedicine is available to allow more patients to participate. Let your patients know the practice is now offering telehealth services when they call the office. Have your office staff help support proactive patient outreach. Additionally, post announcements on your website, patient portals, and other patient-facing communications.

For an optimal patient experience, here are some key considerations:

- Ensure your environment has minimal background noise and adequate lighting for clinical assessment
- Make sure you have a strong internet connection and the appropriate equipment (webcam, microphone, headphones)
- Dress in the same level of professional attire as in-person care
- Turn off other web applications and notifications
- Review patient complaints and records before beginning call
- Speak clearly and deliberately, and pause to allow for transmission delay
- Narrate actions with patient (if you need to turn away, look down to take notes, etc.)
- Verbalize and clarify next steps, such as follow-up appointments, care plan, and prescription orders

Telemedicine coverage is included for CAP members **at no additional charge**, but is conditioned on services being performed within the state of California. There are a few exceptions; for example, in the interest of patient safety and continuity of care, telemedicine coverage will be extended upon request when it is related to patients who temporarily travel outside of California.

To access CAP's comprehensive library of telemedicine resources, please visit CAPphysicians.com/mptelehmed.

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

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