



The Measles Makes a Comeback

by Deborah Kichler, RN, MSHCA

This year saw the largest outbreak of measles in the U.S. since 1994, with 1,250 cases reported as of October 3, largely driven by families choosing not to vaccinate their children. Worldwide, the disease has resurfaced in areas that had been declared measles-free.

So now, measles — the most contagious of vaccine-preventable illnesses — has become a national epidemic and growing health concern. Why? Because parental behavior regarding immunizations has begun to change the statistics.

Pediatric studies have shown an increase in vaccine refusal. Parents who decline vaccinations for their children believe that immunizations are unnecessary. Multiple sources have taken a different stance and challenged the scientific research that has stood for decades. With various degrees of information available, some find it difficult to determine what is a legitimate source.

What can physicians do to help educate and quell the fears of the parents and patients when discussing vaccinations?

There are three groups of patient-parents: **1)** the compliant group — those who follow the guidelines and seek out vaccinations; **2)** the noncompliant group — those who are adamantly anti-vaccine (there is very little, if any, way to engage this group into getting the recommended vaccines); and **3)** those who are vaccine-hesitant. This last group is the one to spend more time with, educating them on the risks and benefits of vaccination. They may have been the parents who heard something on TV or came across something on the Internet and are not sure whom or what to believe. Taking a bit more time with them, explaining the facts and science of vaccinations, may more likely lead them to choose vaccination for their children.

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There are a variety of approaches to education you may take. For example, consider providing a list of trusted sources of vaccine information from various websites. The ones noted at the end of this article provide literature and videos in several languages to assist in the educational process.

Another approach involves sharing examples from your personal experience. Chapman University Professor Jeff Goad, Pharm. D., recommends “personalizing” stories rather than stating statistics. This is the practice used by pediatrician Ruben J. Rucoba, MD. “I spoke of the measles epidemic I witnessed as an intern in 1989 during my first rotation on the infectious diseases floor. I told them about a young boy who came in with the measles, deteriorated, and ultimately died. I related the story to another patient who entered the hospital as an energetic, playful toddler, but left neurologically devastated and dependent on a tracheostomy and G-tube feedings.”

What to Do When Parents Refuse Vaccinations

What if, despite your best efforts, the patient-parent refuses vaccinations for his or her child? A growing number of pediatricians continue to provide vaccine education but are also dismissing patients at higher rates. But first, listen carefully and respectfully to the parents as to their concerns, worries, and questions. Reasons for refusal may be due the cost of the vaccines, concern about the child’s discomfort from multiple vaccine administrations at a single visit, or fear that too many vaccines may be harmful for their child’s immune system.

While there is not a 100 percent risk-free guarantee or effective rate, the physician should share what is and is not known about the risks and benefits of the vaccine in question, attempt to understand the parents’ concerns about immunization, and attempt to correct any misconceptions and misinformation. All discussions, including education, benefits of immunization, and risks associated with remaining unimmunized, should be thoroughly documented in the medical record.

Physicians may also consider having the parent sign a “Refusal to Vaccinate” waiver. Vaccine exemption forms should only be signed if there is medically-justified contraindication to the child’s health with thorough documentation in the medical record. (Refer to California State Senate Bill 276 for guidelines.)

Although the Academy of Pediatrics does not endorse patient dismissal, it is ultimately the physician’s choice. Choosing dismissal or declining a new patient as an option for anti-vaccine patients can be the policy of your office. If the family does not have faith and trust in their caregiver on the issue of vaccinations, that may also weaken the physician-patient relationship if more complicated medical situations arise. Prior to establishing the physician-patient relationship, have a “pre-meeting” or “get-to-know-you” appointment to discuss your practice philosophy and set patient-parent expectations to determine if this will be a mutually beneficial relationship. ↩

Resources:

Refusal to Vaccinate Form

www.aap.org/immunization/refusaltovaccinate

Discontinuing Patient from Practice Guidelines/
Sample Letter [http://www.CAPphysicians.com/
articles/refresher-discontinuing-patient-physician-
relationship](http://www.CAPphysicians.com/articles/refresher-discontinuing-patient-physician-relationship)

Educational Websites:

American Academy of Pediatrics www.aap.org

Vaccine Information www.vaccineinformation.org

Centers for Disease Control www.cdc.gov

Every Child by Two www.ecbt.org

World Health Organization www.who.int

National Foundation for Infectious Diseases
www.nfid.gov

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Physicians can attest to the value of yearly physical checkups and the key role they play in detecting issues early, monitoring ongoing concerns, and mitigating the risk of future complications. They also are keenly aware that despite knowing the benefits of regular checkups, due to a variety of factors, patients do not always abide by an annual exam schedule.

Imagine if patients had a personal concierge guiding them through the process of seeking routine physicals – someone at their side every step of the way, from scheduling appointments and picking up prescriptions, to providing ongoing guidance. It's a safe bet that with this degree of support, patients would be more likely to prioritize their care and engender better outcomes all around.

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With so many competing priorities in professional and family life, it can be difficult to find time for an annual review of your insurance portfolio. However, like the physical checkup, a regular assessment of your insurance coverage will ensure that you are adequately protected on business and personal fronts. Perhaps your practice has hired new staff, purchased new equipment, or moved to a new location.

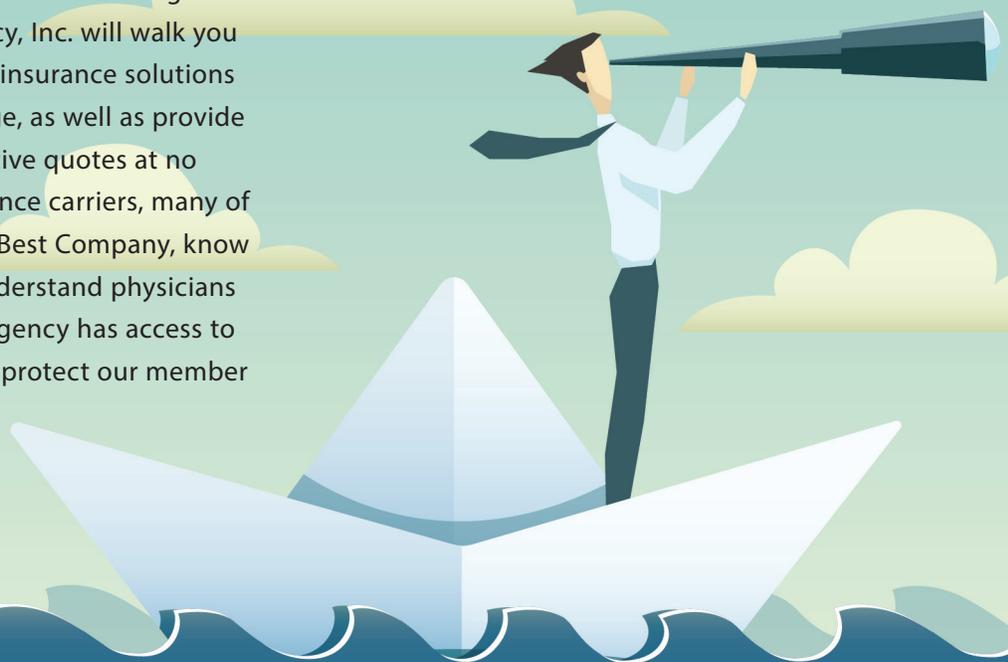
On the personal side, you may have a new addition to the family, a new teenage driver, a new vacation home, or a new boat or other hobby item. Whatever the change, it may increase your exposure both professionally and personally.

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Case of the Month

by Gordon Ownby



Court Says Behavior Contract Did Not Void Physician's Right to Hearing

An appellate court has ruled that a hospital's attempt to manage a staff physician's behavior through a written agreement went too far because the physician's summary loss of privileges could be traced back to patient care issues.

In 2008, PIH Hospital-Whittier warned a staff physician, Abdulmouti Alaama, MD, that he had to work cooperatively with doctors, nurses, and hospital staff and that he would be subject to discipline if he yelled at, verbally abused, or displayed any "physically inappropriate and unprofessional behavior" toward hospital patients or employees. Two years later, the hospital placed the family medicine physician on probation for what it called "unprofessional behavior" directed toward an anesthesiologist and nursing staff during a medical procedure.

In the published Court of Appeal opinion, *Alaama v. Presbyterian Intercommunity Hospital, Inc.*, things did not improve and in April 2012, Dr. Alaama signed a contract with the hospital titled "Behavioral Agreement" in which he agreed to comply with medical staff and hospital bylaws, rules, regulations, and policies. The contract contained a list of specific behavioral requirements including that he would "be readily available and exercise professional courtesy when called upon to discuss a patient's course of treatment or medical care" and that he would not "exhibit any other inappropriate, unprofessional, abusive or harassing behavior" on the hospital premises, such as failing "to address the safety concerns or patient care needs expressed by another

caregiver" or failing "to work collaboratively with other caregivers" at the hospital.

In the signed agreement, Dr. Alaama acknowledged his understanding that a failure to comply with the standards of the hospital medical staff would result in "automatic termination" of his staff privileges. The parties further agreed that any such "automatic termination shall not give rise to any substantive or procedural rights under California law" or the hospital bylaws.

An incident in 2015, however, gave rise to Dr. Alaama's termination of staff privileges and subsequent litigation.

According to the alleged facts relied on by the Court of Appeal, a hospital patient was lying on his stomach, "profusely vomiting" with his "face changing to shades of purple" after an endoscopic procedure. Two nurses and a technician asked Dr. Alaama to move a cart where he was "documenting" on a computer so that they could move a bed into the room and turn over the patient. Dr. Alaama allegedly "responded to each request with words to the effect of, 'No, they can wait.'" One of the nurses complained that Dr. Alaama "showed no concern" for the patient's needs and put "himself first instead of the patient's needs."

The hospital medical executive committee met twice to consider the incident and at the second meeting approved a motion finding that Dr. Alaama violated the behavioral agreement and terminated his hospital privileges. Dr. Alaama filed a lawsuit alleging

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that he was wrongfully denied a hearing under California law and hospital bylaws.

The trial court focused on whether Dr. Alaama's termination was for a non-medical disciplinary reason or whether the action was for a medically disciplinary cause, which would have invoked the right to a hearing under Business and Professions Code Section 809. In finding for the hospital, the lower court judge characterized the termination as arising out of "harassment" of hospital staff.

"They are accusing him of harassment," the lower court judge explained, which was "defined under the agreement as failing to respond to a nurse's concern about patient needs and safety. That is [it] doesn't matter if they are right or wrong. If . . . they raise an issue and he doesn't respond to them, that is considered harassment under the agreement. It doesn't matter whether he actually was causing a safety issue or patient care issue." Under this analysis, the lower court judge said Dr. Alaama was not entitled to a hearing under Section 809.

Disagreeing, the Court of Appeal began its analysis by citing California case law holding that once a hospital appoints a physician to its medical staff, the hospital may not terminate that membership "absent a hearing and other procedural prerequisites consistent with minimal due process protections."

In weighing whether the hospital's action was based on a "medical discipline cause of action," the appellate court looked to Section 805 of the Business

and Professions Code, which states that "'medical discipline cause or reason' means that aspect of a [physician's] competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care."

The hospital argued at the appellate court that its termination did not trigger a Section 809 hearing "because of [Dr. Alaama's] inappropriate, unprofessional, abusive, and harassing behavior toward physicians, nurses, and hospital employees in the workplace when he 'failed to address patient care concerns expressed to him by staff' . . ." The hospital cited its investigator's interview with the anesthesiologist involved in the 2015 incident, who said that Dr. Alaama's conduct "was not detrimental to the patient's safety because the patient was oxygenating well despite the fact that the patient was vomiting."

In ruling that Dr. Alaama was indeed entitled to a hearing, the Court of Appeal said that "even if Dr. Alaama's conduct in connection with the November 2015 incident was not detrimental to patient safety, it was detrimental "to the delivery of patient care" under Section 805.

"And that, under the statute, is enough." ✦

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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Proposed Rule on Stark Law Provisions

by Gabriela Villanueva

The federal government's stated intent to ease healthcare delivery through simplified regulations will address a long-time irritant of physicians: the Stark Law.

Mandated by the Medicare Access and CHIP Reauthorization Act (MACRA), a report to Congress by the Department of Health and Human Services (HHS) included observations on the effects legislation such as the Stark Law were having on the department's shift to the value-based payment models in healthcare. The report outlined options for amending existing fraud and abuse laws in order to reduce waste and increase efficiency, especially as the Centers for Medicaid and Medicare Services (CMS), through the implementation of the Merit-Based Incentive Payment System (MIPS), has consistently and incrementally been moving away from the long-time model of fee-for-service.

As a result of this report, on October 9, 2019, CMS, under the directive of HHS to pursue cost-saving policies, announced a proposed rule to redefine and clarify boundaries regulating the Medicare physician self-referral law, commonly known as "Stark Law."

Enacted in 1989, the bill's official title is the Ethics in Patients Referrals Act. (It was dubbed "Stark I" after the Democrat from California, Representative Pete Stark, who sponsored the initial bill.) When implemented 30 years ago, the statute sought to ban physician self-referral for designated services to Medicare-covered patients that would result in the provider, or an immediate family member, benefitting financially from the referral. In 1995, the original statute was expanded to add provisions for the Department of Health Services and apply aspects of the law to the Medicaid program. The expansion was called "Stark II" and subsequently the entire scope of legislation became known as Stark Law.

The current CMS proposed rules look to update the provisions of the statute by carving out exceptions to some of the regulations that are considered hindering the innovation designed into the value-based models

for delivery of care and cost reduction. Aimed at reducing regulatory burden, CMS' latest "Patients over Paperwork" initiative would be supported by changes to the Stark Law. According to CMS, reducing regulatory burdens and incentivizing coordinated care (highly favored in the era of value-based care), can still further the original intent of law to stop fraud and abuse. The exceptions would apply regardless of whether the arrangements for care are provided to people with Medicare or other federal healthcare programs.

The new proposed rules could deliver a highly anticipated overhaul of these regulations by making it easier for healthcare providers participating in value-based arrangements to coordinate care without fear of consequences from noncompliance with the Stark Law.

As an example, under the proposed rules, specialty physicians could share patient information with primary care physicians to manage care or work with hospitals using data analytics. It also would allow local hospitals to work together on cybersecurity issues without running afoul of data-sharing concerns. In addition, newly created safe harbors would include allowing hospitals to pay physicians incentives as part of CMS-sponsored care models.

By shielding physicians from the steep financial penalties under the Stark Law, the proposal aims to further incentivize physicians to participate in the models of evolving value-based care. ↩

CMS will be taking comments on the proposed rules until December 31, 2019.

Fact Sheet: <https://www.capphysicians.com/cms>

Submit Comments: <https://www.federalregister.gov/public-inspection/current>

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