THE MONTHLY PUBLICATION FOR CAP MEMBERS

CAPsules®

COOPERATIVE OF AMERICAN PHYSICIANS

November 2021

Cooperative of American Physicians Announces Retirement of General Counsel Gordon T. Ownby; CAP Associate General Counsel Douglas Shin Named Successor

Company emphasizes continuity in key role

After 34 years of service to CAP members — 29 as CAP's general counsel — Gordon Ownby will retire at the end of November. Among his many accomplishments, Mr. Ownby created "Case of the Month," the most popular column in the monthly member newsletter and the basis for two popular books.

Prior to becoming a lawyer, Mr. Ownby was a news editor at *The Los Angeles Daily Journal*, a legal affairs newspaper. He began serving CAP physicians in 1987 as a defense attorney in CAP's dedicated law firm, Schmid & Voiles, and became CAP's general counsel in 1992. Mr. Ownby began writing his well-regarded column, "Case of the Month," in 2000 to share with CAP members how closed litigation claims can offer a wealth of risk management lessons. At the time of his retirement, he will have contributed more than 260 columns to the newsletter. Highlighted case studies appear in the CAP-published book, *Medicine on Trial: Risk Management Lessons From Litigated Cases,* now in its second edition.

"Gordon has been a valued part of CAP's growth and development," says Chief Executive Officer Sarah Scher. "While we will have the legacy of his writings with us for years to come, his day-to-day contributions will very much be missed. We wish him much happiness in his retirement."

Mr. Ownby will be succeeded by Douglas Shin, who is currently Associate General Counsel and has worked at CAP since 2012. Mr. Shin earned his Bachelor of Arts degree from the University of California at San Diego and his law degree from Loyola Law School, where he was a member of the Loyola Law Review. He began his career as a legal intern for the technology transfer team at Cedars-Sinai Medical Center and coauthored an article on the commercialization of intellectual property in central and eastern Europe. He also previously worked as a litigator, defending numerous clients in the general and medical malpractice liability, employment, and healthcare arenas, including settlement of numerous matters and arbitration.

Said Ms. Scher, "Doug is an outstanding attorney who has distinguished himself within our organization and in general. We are confident that he will be of tremendous support to our boards, committees, and physician members and help lead CAP to continued growth and excellence in achieving our mission to support healthcare providers with the best products and services."

CAP members can continue to follow "Case of the Month" as a regular *CAPsules* feature.

Douglas Shin

Case of the Month

by Gordon Ownby

Don't Be Misled by Different Test Report Formats

Faxed reports, portals, electronically transmitted reports — physicians have had to adapt to a number of different formats in which they receive their reports. The various formats used in modern reports, plus the longstanding scourge of confirmation bias, make paying close attention to all such communications vital to patient safety.

Dr. GP, a general practitioner, had been caring for his patient for a variety of issues for 27 years prior to the 62-year-old gentleman undergoing a cholecystectomy. In a copy of the report that Dr. GP received via fax, the surgeon for the procedure included in his post-op diagnosis "cirrhosis of the liver," and noted in his operative report that the liver was mildly cirrhotic. Dr. GP did not receive a copy of a lab test ordered by the surgeon two days post-op which showed the patient as positive/abnormal for Hepatitis B.

When Dr. GP saw his patent three days following the surgery, the physician's assessment included "elevated liver enzymes, pending workup." Enzymes from the lab ordered by Dr. GP were only slightly elevated, though labs ordered by Dr. GP 10 years earlier showed higher values. Results for a hepatitis panel ordered by Dr. GP gave the first result as "HBsAg Screen: positive," which meant that the surface antigen for Hepatitis B was positive. On the following lines, the report listed negative findings for Hepatitis A and for Hepatitis B core. The result for Hepatitis C showed a value within the numerical range. Several days later, however, Dr. GP telephoned his patient to advise him that he was positive for Hepatitis A and that no further action was needed.

Dr. GP saw the patient the next month to follow up on the labs. The assessment included elevated liver enzymes, improving, but the chart made no mention of the positive Hepatitis B test result, nor was any mention included regarding the cholecystectomy surgeon's post-op diagnosis of "cirrhosis of the liver."

Though lab tests ordered by Dr. GP 18 months later included elevated liver enzymes, Dr. GP charted his call to the patient as relaying "stable lab" results with low Vitamin D and the need for a flu vaccine. Labs taken another year hence also showed elevated liver enzymes plus decreased platelets, though the chart reflects Dr. GP's call to his patient reported "stable lab" results and the need for a flu vaccine.

The next year, the patient was seen in the emergency room for bloody urine and an abdominal CT showed cirrhosis of the liver. When the patient saw Dr. GP for the final time after that episode, Dr. GP referred him to a gastroenterologist. The next month, the patient was admitted to the hospital after vomiting blood. The GI's assessment was gastrointestinal bleed, peptic ulcer disease versus cirrhosis versus esophagitis versus upper gastrointestinal malignancy versus varices. The patient signed out against medical advice with discharge diagnoses that included hematemesis, status post EGD, cirrhosis, and liver mass. The patient visited another hospital and a week later, a hepatologist diagnosis probable hepatocellular carcinoma, Hepatitis B, cirrhosis, and portal vein thrombosis and recommended immediate viral therapy with transplantation evaluation.

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Following several months of infusion therapy, the patient was readmitted with severe abdominal pain, treated with morphine, and placed on DNR. He was discharged home for hospice care and died one week later. The death certificate lists the cause of death as cardiac arrest and liver cancer. A lawsuit against Dr. GP initiated by the patient's family was resolved informally.

Viewing Dr. GP's actions on the various reports, it may be relevant that the physician was converting the office to electronic medical records from paper documents. Further, the lab report's listing of the Hepatitis B surface result *first* — where a physician may be accustomed to seeing the *Hepatitis A* report — demonstrates the need to assume nothing (and perhaps take a "time out") when receiving a report in an unfamiliar format.

A physician who misses findings in a written report also raises the specter of confirmation bias, a phenomenon that leads people to see or hear what they expect to see or hear, regardless of the actual information. According to healthcare risk managers, confirmation bias is a real threat to patient safety if not overcome.

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

Mitigation Strategies to Reduce the Occurrence of Telehealth-Related Adverse Events

by Deborah Kichler, RN, MSHCA

Almost two years into the pandemic, the widespread use of telehealth technologies does not appear to be going away any time soon, if at all. The COVID-19 crisis has accelerated the use of telehealth offering technology-enabled health and care management and delivery systems that extend capacity and access.[1]

The telehealth capabilities spectrum goes well beyond the patient-physician video encounter. Comprehensive telehealth services can include data storage and review (images and labs), "apps," portals for communication and education with patients, real-time care delivery (virtual visits), and real-time monitoring (BP, glucose, and EKG). Telehealth is expanding our capabilities to provide quality patient-centered care.

Now is the time to evaluate and strengthen your telehealth program/plan to meet your practice's goals and your patients' needs. Identify the objectives of your telehealth program, the services that will be offered, and the operational oversight. The following steps provide guidance on how to manage a productive and effective telehealth program.

1. Workflow: Develop and define workflows and new roles. Consider workspace, telemedicine etiquette, and the appropriate patient population for telemedicine services.

2. Operations: Review staff education and training, competencies, privacy issues, state guidelines, informed consent, and quality review.

3. Policies and Procedures: Include scope of practice for providers and staff and standards of care.

4. IT Functionality: Ensure HIPAA-secure platforms, cyber security controls, and integration of visits and monitoring into the EMR.

5. Communications and Care Coordination: Consider patient preference, patient resources, language services, pre-visit planning, post-visit patient education and referrals, documentation, and follow-up/follow-through protocols.

6. Reimbursement: Review state laws and CMS requirements to determine what level of reimbursement, if any, can be expected for a telehealth program.

With new positive advances in virtual care comes new liability risk for practitioners providing medical advice and care to patients that they are not seeing face-to-face. Potential telehealth risks to be aware of include:

- Legal/regulatory compliance (state laws, CMS requirements regarding telemedicine, HIPAA compliance).
- Inadequate training in the use of technology.
- Technology failures: poor image quality, lags.
- Inadequate patient selection criteria (specialty-specific guidelines).
- Physicians practicing from home: bandwidth interruption/distraction, privacy.

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- Obtaining informed consent, including video limitations.
- Documenting the encounter: especially follow-up care, referrals, prescriptions.
- Verifying medical professional liability (MPL) coverage for virtual visits across state lines.
- Verifying applicable laws in states where care is delivered: informed consent, prescriptions.

Potential malpractice case allegations related to this expansion of telehealth can include:

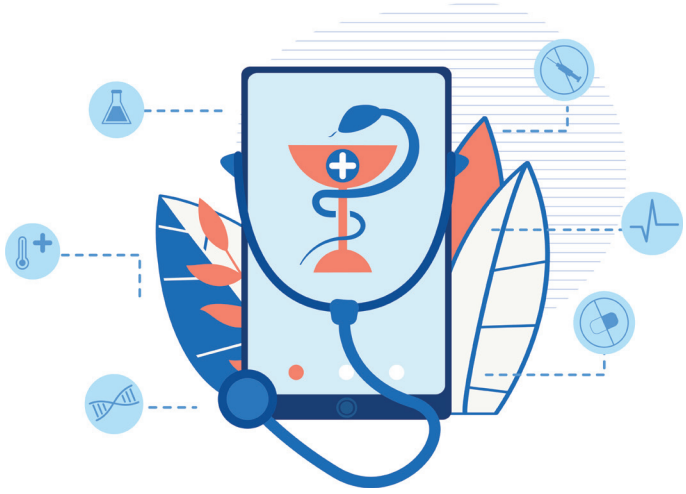
1. Failure to diagnose and correctly triage.
2. Incorrect interpretations of images from home or remote, and miscommunication.
3. Failure to communicate presenting symptoms to a remote examining specialist and resulting failure to diagnose.
4. Systemic failure of a device/app to monitor.

Recommended Risk Management Mitigation Strategies:

- Determine which patients can be appropriately seen by a video encounter and which visits must occur in person.
- Consider patient access of broadband, education levels, age, and language barriers.
- Educate patients on how to use the program and its benefits.
- Verify the patient's identity (driver's license and specific questions regarding visit).
- Document informed consent and include the limitations of a video exam, and technology interruptions.
- Document the video encounter in the EMR and include test ordering and results, any communication with patient/family/referral/coordination with other providers, referrals and follow-up care including timeframe, and technical issues encountered.
- Verify the patient's understanding, especially follow-up steps.
- Focus on the patient experience.
- Re-examine the Best Clinical Scenarios for Use of Telemedicine (ATA-American Telemedicine Association).
- Seek out specialty-specific guidelines (APA-American Psychological Association, ACR- American College Radiologists, ACEP- American College of Emergency Physicians).

Telemedicine is evolving rapidly. Telemedicine risk is new and also rapidly evolving. So far, only a very small number of claims have occurred. Telemedicine risk can be managed with planning and careful thought. Know the limits of a virtual encounter. To lessen the likelihood of any additional malpractice risks, physicians should adhere to licensing rules, comply with HIPAA regulations, follow the same standards of care as they would for in-person treatment, and document appropriately.

Deborah Kichler is a Senior Risk Management and Patient Safety Specialist for CAP. Questions or comments related to this article should be directed to DKichler@CAPphysicians.com.



[1]The American Telemedicine Association, 2019

Webinar: Telehealth: Utilizing Adverse Event Data to Proactivity Identity and Mitigate Risks (ECRI, July 2021)

Telehealth (ecri.org, March 30, 2020)

Preventing Water Damage in Your Property with Smart Sensor Technology Could Save You Thousands

November 2021

Did you know that water damage is the most common cause of property damage to businesses? As a business owner and physician, there are a variety of risks in your practice you must worry about every day. Water damage shouldn't be one of them. If you own or lease property or office space for your practice, it's best to have a plan in place and be prepared.

Unexpected water leaks or broken pipes can quickly disrupt your office, costing you valuable time and money. Water damage not only impacts your medical equipment and office property, but it can also impact your business income if you are forced to close while your office is repaired.

That's why CAP Physicians Insurance Agency (CAP Agency) is pleased to partner with Hartford Steam Boiler (HSB) and The Hanover Insurance Group to provide you with a Smart Sensor program for your business — all at no cost to our members who purchase or have a business owner policy through CAP Agency.

How does the program work?

The Smart Sensor program features sensor equipment that sends you real-time alerts to help prevent costly water damage and repairs. With the program, your practice will receive easy-to-install sensor devices that will automatically monitor your property 24/7 and alert you via a text message or phone call if there are any system issues such as water leaks, temperature changes, mold detection, and more. With this valuable risk management offering, you'll receive:

- **Real-time monitoring of your building and equipment** — If an issue occurs after hours or on the weekend, you'll receive an alert immediately to your phone or email.

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• **24/7 professional support** — you will have access to the monitoring and support center any time of day.

• **Easy installation** — the sensors only take a few minutes to install, and there is a team of professionals to help walk you through the process.

What can you save by signing up?

Customers who have signed up have already saved their business from a loss. Take a look at these examples:

The filter of a water line came off in a building causing water to spill all over the floor. An actionable water leak alert was sent, and within minutes, staff was able to respond to bypass the flow of water. As a result, the office did not have to cancel patient appointments or deal with the inconvenience of renovating the office after a water leak event.

Dollars saved: $100,000

A pipe valve failed causing water to spray into a patient room and storage closet of a closed office. A high-humidity alert from the sensor prompted staff to visit the office and shut off the water in time to contain the leak. The alert prevented costly business interruption, loss to medical supplies, and damage to valuable medical equipment.

Dollars saved: $40,000

The sensor program gives me peace of mind knowing the building is monitored 24/7 when we are not onsite. Had it not been for the alert, we could have suffered major structural losses and an interruption in care for our patients." – Medical Office Supervisor

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Get Started

If you already have a business owner's policy with The Hanover Insurance Group through CAP Agency, signing up to get your free Smart Sensor is easy. Simply visit our dedicated Smart Sensor website to get started. It takes just a few minutes to sign up.

Sign up here: **https://www.sensorsignup.com/hanover-medical/en/home.html**

If you'd like to learn more about insurance solutions available to you through CAP Agency and The Hanover Insurance Group, contact us today by calling 800-819-0061 or emailing CAPAgency@CAPphysicians.com.

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November 2021

Who Draws the Lines; Who Tells the Story?

by Gabriela Villanueva

California is only one of seven states in the country whose voting district lines are drawn by an independent citizens commission. For the rest of the union, state Legislatures and governors draw the lines following completion of the U.S. Census. Lines drawn by such elected officials, of course, are prone to more acutely reflect the party in power. Based on a voter mandate, California endeavors to be more balanced.

The independent California Citizens Redistricting Commission was established in 2008 via the state's ballot initiative process. The 14-member redistricting commission is made up of five Democrats, five Republicans and four commissioners who are not affiliated with either party. It draws political boundaries every 10 years for congressional, state Senate, state Assembly, and Board of Equalization district maps.

Two crucial data points required for the commission to draft fair and representative districts include the 2020 Census data and direct community input. "We will be looking at census data throughout the state, but also in conjunction with testimony from communities on the ground," said Commissioner Sara Sadhwani, of Los Angeles County. "Until we have both of those data points, we will not be able to tell exactly where a seat will be lost or changed or transformed." Losing a congressional district in California as a result of the 2020 Census complicates the commission's work.

Eric McGhee, a senior fellow at the Public Policy Institute of California, said the Bay Area, the Sacramento region, and the Inland Empire have seen the most population growth in the state and could hold on to their congressional districts. "Los Angeles has grown, but not fast enough ... and hasn't grown as much as the state as a whole," he said. "That means it's going to lose districts to other parts of the state."

Of the country's 435 congressional districts, California's share of 53 congressional seats will be reduced to 52 seats beginning with the 2022 mid-term elections.

An announcement in late September by Congresswoman Karen Bass (D-Los Angeles) that she will be running for the office of Mayor of Los Angeles may have potentially made the task of the commission a bit easier when redrawing lines to eliminate the congressional seat California lost.

Complicating matters not only for the commission but for the entire election apparatus was the long list of problems in the 2020 count, including insufficient funding for preparation, the previous administration's attempts to add a citizenship question and block undocumented immigrants from being counted for apportionment, and the COVID-19 pandemic, all causing major delays for the survey and delivery of data.

Under the California Constitution, the redistricting commission is mandated to submit its final maps to the Secretary of State by August 15, 2021, but census data were not released by the U.S. Census Bureau until August 12, 2021. The six-month delay in receiving the data made it impossible for the redistricting commission to meet its August 15 mandate. With insufficient time for the commission to undertake the redistricting process to approve new district lines in time for the statewide direct primary originally marked for March 2022, that election was moved to June 7, 2022, by legislative decree.

While traditional redistricting guidelines include keeping swaths of communities as whole as possible, especially minority communities, a significant finding revealed by the 2020 Census was the growth in individuals who identify as multiracial. This potentially adds another challenge for the redrawing of lines. Nationwide, in 2010 nine million people identified as multiracial compared to 2020 when now 33.8 million identify as multiracial. Some of the changes may be due not only to actual increased diversity, but also to changes in how people identify themselves. The bureau's design, data processing, and coding procedures have made it easier for respondents to identify as more than one race.

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"It looks like most of the increase in the diversity index is because the current census worked hard to identify diversity that was already there, but it will be some time before we know for sure," said Steven Martin, a senior demographer at the Urban Institute, in *The Washington Post*. This change adds a complexity to the redistricting process that has not been accounted for previously.

On September 27, Governor Newsom signed AB 37 by Assemblyman Marc Berman (D-Santa Clara) permanently requiring a vote-by-mail ballot be mailed to every active registered voter in the state. Starting with the 2022 primaries in June that will include candidates in (hopefully) newly drawn districts, all registered voters can expect a mail-in ballot option in California elections moving forward.

The commission will be submitting its final maps to the Secretary of State in February 2022. In the meantime, community input is highly recommended. See links below for more information.

https://drawmycacommunity.org/

https://www.wedrawthelinesca.org/

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

Adverse Event Management Support Available Exclusively for CAP Members

Through CAP Cares, CAP members can receive confidential and objective support after an adverse patient event occurs, with guidance at every stage of the process — all as a free benefit of your CAP membership.

CAP's experienced risk management team can help you:

- **Conduct initial fact gathering and analysis**
- **Prepare for likely questions and discussions among necessary parties**
- **Coordinate patient disclosures and maintain the treating relationship**
- **Properly document the activities surrounding the outcome**

Assistance Available 24 Hours a Day, Seven Days a Week . . . for Support When You Need It Most

When an unexpected outcome occurs, taking key steps and managing a thoughtful resolution process could help you avoid a lengthy and costly legal conflict and help protect your reputation.

For assistance, contact the

CAP Cares Hotline

1-800-252-0555

CAP members are encouraged to take advantage of this *free* benefit to help lower the risk of medical malpractice litigation when and if an adverse patient event occurs.

Ask My Practice

by Andie Tena

Critical Steps to Take Ahead of Your Practice Relocation

Moving your practice can be a daunting task, but there are several scenarios when relocating may be a good idea. Lease negotiations gone awry, changing patient demographics in the area, health plan/hospital acquisitions of real estate, and expansion of the practice may have you contemplating a potential office relocation.

Before you make a decision, here are a few things to consider:

- How will the move affect staff? Will it be a further commute for your key team members and will it make it difficult to retain them?
- Will current patients easily find the new location and is there sufficient free parking?
- Is there a need for your specialty in the area and if not, who are the entities/hospitals in the community you can align with to secure referrals?
- Will there be build-out costs for the new space and who will be responsible for the cost?
- How will the new lease cost affect your bottom line now and moving forward? Are there additional costs for cleaning, parking access, and common area maintenance?
- Is there an opportunity to buy the building?
- Who is responsible for HVAC repairs and replacement?
- Will your move impact your business insurance premiums?
- Will you need new equipment?

These are just a few factors that can impact your long-term profitability and security.

Once you have made the decision to move forward, you will need to find and vet a new space — the most important and perhaps most challenging step that can make or break your entire decision. Before you negotiate a lease, ensure a thorough investigation as follows:

- Conduct a financial analysis to determine your wants and needs. Some things to consider are the size of your suite, your minimum and maximum of the new base rent, your desired maximum term, the cost of your parking requirements, and so on.
- Conduct a market analysis to determine the area's market rents and the availability of space in the target area. Determine what the landlord's concessions are.

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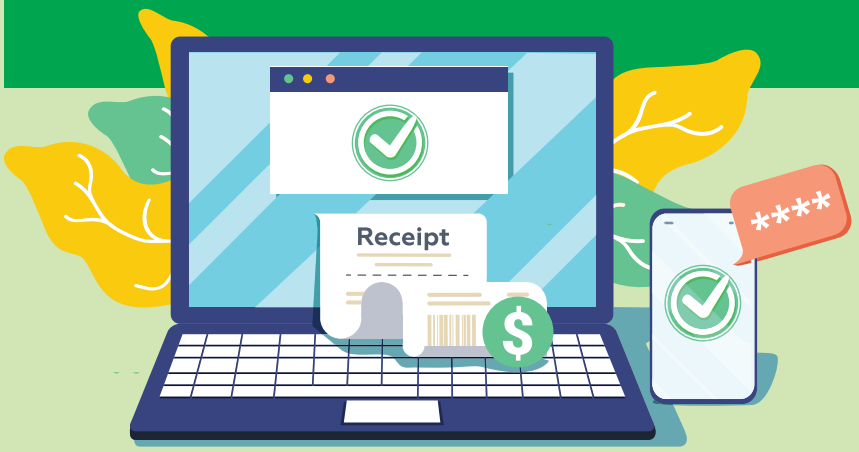
- Tour several comparable sites to determine the pluses and minuses of each.
- Analyze and compare the findings of the strategic planning, market analysis, financial analysis, and the site tours.
- Propose your terms and concessions to the landlord's leasing agent, then prepare for the landlord's rejection or counter proposal, which starts the negotiation phase.

Moving practices requires a lot of coordination. A step-by-step plan will help you organize the many moving parts involved with relocation. As far as six months out, you should already be working with your staff to ensure a seamless transition. Many physicians and administrators don't know where to start nor do they have time to commit to such a huge undertaking — and that is understandable given the demands of the busy practice.

As a benefit of your membership, you can take advantage of CAP's *My Practice* program for free practice management and business assistance. In addition to being available for general practice-related inquiries, *My Practice* can provide you with support for practice transitions and relocations and connect you with free commercial real estate services offered by Bailes and Associates, exclusively for CAP members.

My Practice is pleased to help you get started by providing you with these helpful tips provided by the by the Medical Group Management Association (MGMA) and Bailes and Associates. Get the MGMA checklist here: https://www.mgma.com/MGMA/media/images/resources/MemberTools-MedPracticeRelocation_Checklist.pdf?ext=.pdf

To learn more, contact Andie Tena, CAP's Director of Practice Management Services, at ATena@CAPphysicians.com or via phone at 213-473-8630.



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- **No more paper:** Your bill will be emailed to you so you can reduce clutter and save on increasing postage costs.
- **It's secure:** You can access your account 24/7 online at www.CAPphysicians.com.

Enroll in paperless billing today with the click of a button. Here's how:

1. Visit **https://member.CAPphysicians.com** to log into your CAP account. If you do not have an account, you will need to visit **https://member.CAPphysicians.com/register** to create one.
2. Once logged in, select the green "Set Up Paperless Billing" button to the left of the screen.
3. Select the "Via Email Only" button.
4. Verify your email address and click the "Save Changes" button.

It is that easy! Enroll Today!

For assistance with your account or if you have questions about your membership, please call **800-610-6642** or email **MS@CAPphysicians.com**.

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