THE MONTHLY PUBLICATION FOR CAP MEMBERS

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Case of the Month

High Court Attempts to End 'Confusion' on Peer Review Challenges

by Gordon Ownby

The California Supreme Court has ruled that while the path is narrow, a physician can avoid an "anti-SLAPP defense" when alleging that a hospital's peer review decision was retaliatory.

The Supreme Court's decision addresses some shortcomings that it saw when the case was seen by the California Court Appeal in 2017 ("Case of the Month," August 2017). The case, *Bonni v. St. Joseph Health System*, involves an area of law that the Supreme Court said "has generated confusion in California's courts" when applied to hospital peer review: A legal defense available to defendants in California called an "anti-SLAPP" motion. "SLAPP" stands for "strategic lawsuit against public participation" and the motion allows defendants to seek an early dismissal of harassing lawsuits concerning free speech.

To win an anti-SLAPP motion, a defendant must make a threshold showing that the plaintiff's claim arises from a protected activity (in this case, the peer review process).

According to the facts relied on by the Supreme Court (all of which are subject to later proof), Dr. Aram Bonni, a surgeon, alleges that two hospitals and members of the medical staffs unlawfully retaliated against him for raising concerns about the performance of a robotic assistant that resulted in complications in his patients. Dr. Bonni alleges the retaliation for his complaints began with the suspension of his staff privileges and culminated in the termination of those privileges after peer review.

Dr. Bonni sued St. Joseph Health System, Mission Hospital Regional Medical Center, various affiliated entities, and eight individual physicians involved in the disciplinary process. He claims the hospitals unlawfully retaliated against him for raising patient safety concerns by summarily suspending him, reporting the suspensions to the state medical board, subjecting him to lengthy and humiliating peer review proceedings, defaming him, and ultimately terminating his hospital privileges.

The hospitals contend that any claim arising from the peer review process necessarily targets protected speech and therefore must be protected via anti-SLAPP protection.

But the Supreme Court would not go that far.

"While some of the forms of retaliation alleged in the complaint – including statements made during and in connection with peer review proceedings and disciplinary reports filed with official bodies – do qualify as protected activity," the Court said, "the discipline imposed through the peer review process does not."

Prior to reaching the Supreme Court, the trial court granted the defendants' anti-SLAPP defense motion but that decision was overturned by the Court of Appeal,

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which focused on an alleged *retaliatory motive* as a reason to defeat the anti-SLAPP motion.

In its recent decision, however, the high court said that it did not agree with the Court of Appeal's conclusion that allegations involving retaliatory or discriminatory motives were sufficient to defeat an anti-SLAPP motion. Instead, the Supreme Court explained, there must also be "various outward manifestations of a defendant's alleged wrongful intent."

The high court began its analysis by noting that California's anti-SLAPP statute is "designed to protect defendants from meritless lawsuits that might chill the exercise of their rights to speak and petition on matters of public concern." The anti-SLAPP motion involves two steps. First, the defendant must establish that the challenged allegations arise from protected activity in which the defendant has engaged. Second, for each claim that does arise from protected activity, the plaintiff must show that his or her claim has "at least minimal merit." If the plaintiff cannot make such a showing, the court will strike the claim.

The high court's decision in *Bonni* involved the first step of that process, i.e., determining whether Dr. Bonni's claims arise from protected activity. In proceeding, the court noted that while the hospital's motion seeks to strike Dr. Bonni's retaliation claim in its entirety, the lawsuit actually alleged at least 19 distinct acts or courses of conduct allegedly undertaken in retaliation for Dr. Bonni's complaints of unsafe conditions.

Stating that courts should analyze each claim for relief to determine whether the acts are protected, the Supreme Court reviewed the range of allegations made by Dr. Bonni, with the hospitals bearing the burden of showing that each allegation by Dr. Bonni rests on protected activity. In the end, high court found that while various *communications* made during the peer review process were protected from Dr. Bonni's suit (including statutorily required reports to the medical board), the actual peer review *decision* was not.

The court noted that Dr. Bonni's retaliation claims rested primarily on California Health and Safety Code Section 1278.5, which forbids health facilities from discriminating or retaliating against medical staff members and others for presenting complaints concerning the quality of patient care to other members of the medical staff, the facility, or other responsible entities. A claim under the statute requires "proof of discriminatory treatment" which may be shown "by any unfavorable changes in" a medical staff member's "contract, employment, or privileges . . . or the threat of" such changes. The high court said that the operative complaint by Dr. Bonni alleges that the hospitals retaliated against him for raising patient care concerns by engaging in 16 principal adverse actions or categories of conduct.

According to the court, these allegations "supply the necessary element of retaliation claims" under the statute.

In doing so, however, the court pointed out that some of the alleged retaliatory actions underlying the complaint – including defamation and "character assassination" – describe the kind of speech activities that are protected by the anti-SLAPP statute. "Because peer review proceedings are official proceedings, any statements in connection with the issues considered in such proceedings – such as criticism of a doctor's competence supplied to a body reviewing his or her hospital privileges – are protected activity under the anti-SLAPP law."

The court said the same protections would apply against Dr. Bonni's allegation that defendants subjected him to a "lengthy and humiliating peer review process."

The court noted the difference, however, when Dr. Bonni's complaint alleges "retaliation through various adverse actions – most prominently, the suspension and eventual termination" of his hospital privileges.

"The remaining issue is whether the adverse actions the hospitals took, based on their view that [Dr.] Bonni's competence was suspect, are likewise shielded. We conclude that the anti-SLAPP statute does not extend that far."

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"At bottom, disciplining a doctor based on the view that the doctor's skills are deficient is not the same as making a public statement to that effect," the court explained. "The latter is, or may be, speech on a matter of public concern. The former is not speech at all."

With the allegations of retaliation in the hospitals' actual decisions not subject to an early anti-SLAPP defense (and thus subject of continuing contention), the Supreme Court sent the case back to the Court of Appeal to now consider whether Dr. Bonni met his "second-step burden" to show that his other claims related to *communications* have "at least minimal merit" to avoid being knocked out by the anti-SLAPP motions.

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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Healthcare Disparities – How Can We Shrink the Gap?

by Monica Ludwick, Pharm.D

Inequities in healthcare — such as lack of health insurance, unaffordable medical expenses, and structural racism in healthcare — create disparities in care and make the system more costly and less effective. One study estimates that eliminating racial/ethnic health disparities would reduce healthcare costs by $230 billion and indirect costs of excess disease and mortality by more than $1 trillion over four years.[1] Despite the best efforts of physicians and other healthcare professionals, health trends are moving in the wrong direction. Every day, health administrators face multiple real-world examples of health disparities, recently heightened by the COVID-19 pandemic. Healthcare providers and healthcare systems must play a major role in advancing health equity to prevent needless suffering, premature deaths, and avoidable costs.

Our nation, considered the most prosperous in the world, has rising rates of obesity, diabetes, and hypertension. In fact, a study published by the *New England Journal of Medicine* predicts that by 2030, several states will have obesity prevalence close to 60 percent, while the lowest states will be approaching 40 percent. The researchers predicted that nationally, severe obesity will likely be the most common BMI category for women, non-Hispanic black adults, and those with annual incomes below $50,000 per year.[2] The COVID-19 pandemic has only added more dismal statistics. According to new federal data, in the first six months of 2020, the U.S. life expectancy dropped by a full year. What's even more alarming is that the life expectancy of an African American dropped by three years during the same time frame.[3]

Leading the change to confront the public health crisis

We are fortunate to have physicians and other healthcare professionals who are passionate about improving the health of their patients and communities, and who are dedicated to achieving greater equity for those who experience worse health outcomes because of inequities.

Physicians are ideally positioned to not just talk about these issues, but to act upon them. Many people talk about doing what's right for healthcare. Physicians can make an immediate impact by utilizing tools that can remove barriers that interfere with patient care and drive the future of medicine through improved technology, physician training, and education.

Removing barriers by advocating for patients

Through advocacy and by influencing public policy, physicians can fight to ensure that patients have access to needed health coverage. Too many Americans are uninsured and underinsured and can be one medical bill away from draining their family's savings. Medical organizations at the state or national level — such as the American Medical Association (AMA), the National Medical Association, and American Medical Women's Association — can also help physicians engage in healthcare advocacy efforts. The American Academy of Family Physicians published the EveryONE Project (www.aafp.org/family-physician/patient-care/the-everyone-project.html) that offers strategies for use in your practice to help improve patient care and outcomes. The toolkit can be used as a guide to help

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physicians become involved in health policy by addressing key drivers of health outcomes and health inequities for state and local governments.

Through advocacy, physicians with the Behavioral Health Integration Collaborative have called on policymakers to enforce mental health parity laws to allow fellow physicians to better care for patients diagnosed with a substance use disorder. Although reported estimates of certain mental disorders, substance use, or substance use disorders are not generally higher among racial and ethnic minority groups, persons in these groups are often less likely to receive treatment services.[4]

Improve physician training and education

There are many organizations that have focused their efforts on improving healthcare disparities. The AMA policy on reducing disparities in healthcare aims to increase awareness of racial and ethnic disparities in healthcare among the general public. The AMA provides a toolkit entitled, *"Working Together to End Racial and Ethnic Disparities: One Physician at a Time"* (www.ama-assn.org/print/pdf/node/44501), that offers physicians information on topics such as culture competence and literacy.

The Health Resources and Services Administration (HRSA) provides extensive resources for healthcare professionals on cultural competency, health literacy, and limited English proficiency. The following are two links for free online training and a library of cultural competency resources.

- Unified Health Communication: Addressing Health Literacy, Cultural Competency, and Limited English Proficiency. https://www.migrationpolicy.org/sites/default/files/language_portal/HRSA_0.pdf
- Cultural, Language, and Health Literacy Resources for Health Care Providers https://www.hrsa.gov/about/organization/bureaus/ohe/health-literacy/culture-language-and-health-literacy

Summary

Today, more than ever, we need healthcare professionals and collaborators to pave the way to make our health system more accessible, more affordable, and more effective, with improved outcomes for all. We need to band together to truly improve the health of our nation.

Monica Ludwick *is a Senior Risk Management and Patient Safety Specialist for CAP. Questions or comments related to this article should be directed to MLudwick@CAPphysicians.com.*

[1]LaVeist TA, Gaskin D, Richard P. Estimating the economic burden of racial health inequalities in the United States. Int J Health Serv. 2011;41(2):231-238.
[2]Ward, Zachary et al. Projected U.S. State-Level Prevalence of Adult Obesity and Severe Obesity. *New England Journal of Medicine,* December 19, 2019.
[3]Santhanam, Laura. "COVID-19 has already cut U.S. life expectancy by a year. For Black Americans, it's worse." PBS, February 2021, https://www.pbs.org. Accessed August 28, 2021.
[4]McKnight-Eily LR, Okoro CA, Strine TW, et al. Racial and Ethnic Disparities in the Prevalence of Stress and Worry, Mental Health Conditions, and Increased Substance Use Among Adults During the COVID-19 Pandemic — United States, April and May 2020. MMWR Morb Mortal Wkly Rep 2021;70:162–166.

New Disclosure Statement Now Available

Each year, we publish the Disclosure Statement, which gives an overview of CAP and MPT operations, pursuant to California Insurance Code Section 1280.7. The 2021 Disclosure Statement is now available and can be reviewed at any time in the Members Only section of the website at member.CAPphysicians.com. Copies are also available by contacting CAP at 800-252-7706.

Mitigating Business Risks in the Medical Practice

Medical practices are significant legal business entities and need to carefully consider common financial risks. While it is impossible to remove 100 percent of risk, physicians should be reminded that they are vulnerable targets with unique needs for powerful protection, even outside of the clinical setting.

When it comes to your business, it may be overwhelming to evaluate the various areas that can put you at risk for an accident or lawsuit. Many times, physicians do not consider how a fire or flood could damage equipment, property, and files, or how financially damaging it can be for a delivery person to get injured on your property. Have you ever thought about how you would recover from theft of your medical equipment or business property?

Believe it or not, these scenarios happen more often than you think and the impact on your practice can be far reaching. Practice closure, costly injury-related medical bills, court and legal fees, inventory replacement for damaged goods, and equipment repair or replacement are just some of the challenges you may face because of a business-related accident or lawsuit.

While there are several mitigation strategies to implement to reduce your risk, the best protection to consider is a Business Owners Policy (BOP), which combines a wide range of liability and property/casualty coverage into a single package. Although these policies may be purchased or customized as individual policies, it is generally easier and less expensive to purchase them together.

A good BOP policy:

- Provides insurance against alleged claims of injury or damage caused by physicians or their employees (not from malpractice) including cost of legal defense and settlements
- Repairs or replaces damaged buildings, equipment, or other business property
- Reimburses lost income or costs if the practice closes following a loss to property
- Covers the cost of replacing or restoring damaged records or files due to a property loss
- Pays for medical costs of individuals other than employees who are injured at your practice

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While a BOP policy will cover the financial damages associated with a non-employee, non-clinical injury that occurred in your practice, it will not cover employee injuries occurring as a result of a workplace accident. Slips, trips, falls, falling objects, cuts and lacerations, biological hazards, needle sticks, and chemical and drug hazards are just some of the common risks in the medical practice that can easily cause an employee injury.

Most medical practices are likely well-acquainted with a safety-first culture and provide the necessary OSHA training for employees to help avoid accidents of any kind. However, accidents will happen. That is why all California employers are required to have workers' compensation insurance. Failure to do so may results in heavy fines and penalties.

When an injury occurs on the job, both productivity and profits suffer, yet many employers continue to be inadequately covered or not covered at all. Workers' compensation insurance protects you and your employees.

A good workers' compensation policy:

- Covers the medical expenses of the injured employee
- Covers the employee's lost income
- Helps the employer return their employee to work sooner
- Protects the business owner from accident-related lawsuits
- Ensures a seamless and effective claims process

Pricing for workers' compensation varies but is primarily driven by gross payroll costs and claims history. When shopping for insurance, physicians should find a trusted financial advisor to advise them on how much coverage they need. If possible, physicians should either consolidate their insurance business with an agency that can handle all their insurance needs or create visibility of their entire portfolio for their advisor to see.

CAP Physicians Insurance Agency, Inc. (CAP Agency) is a full-service insurance agency created to support CAP members. The Agency's licensed and trained professional insurance agents have expertise in all lines of business and personal insurance coverage and know healthcare. They can provide you with a comprehensive review of your risk exposures, assess your current coverage, and provide you with comparative, competitive quotes at no cost to you. To learn more, call 800-819-0061 or email CAPAgency@CAPphysicians.com.

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What's Ahead for Nurse Practitioners

by Gabriela Villanueva

The longtime effort in California to expand the scope of unsupervised care by nurse practitioners (NPs) is beginning to take form. AB 890 by Assemblyman Jim Wood (D-Eureka) went into effect on January 1, 2021. As described on the Assemblyman's official web page: "This bill will allow nationally certified nurse practitioners, after completing specific transition requirements, to practice to the full scope of their license independent of physician oversight. Twenty-two other states allow full practice authority of nurse practitioners. Increasing the number of primary care health care practitioners will increase access to care for many more people in California, especially in underserved and rural areas."

It should be noted that Assemblyman Wood represents a very rural part of the state and that the full implementation of AB 890 will come in tiers as the new law requires additional training and certification.

Traditionally, the Nursing Practice Act has provided for the certification and regulation of nurse practitioners by the Board of Registered Nursing (BRN). Existing law authorizes the implementation of standardized procedures for a nurse practitioner to perform certain acts.

The Nurse Practitioner Advisory Committee (NPAC) was established by AB 890 to advise and give recommendations to the BRN Practice Committee, which will then report to the full Board. BRN staff are in the process of drafting AB 890 regulations and are prioritizing transition to practice regulations.

The Board, by regulation, is required to define minimum standards for nurse practitioners to transition to practice independently and expand their scope of care. AB 890 created two different categories of NPs, defined by the settings in which they practice and named for the section of the state code in which the law resides. Each category has different requirements the NP must complete before being allowed to practice without physician supervision. The two categories are:

Category 103 NPs – Work in a Collaborative Setting

Practice Setting 103 NPs work in practice settings in which there is a collaborative medical team, such as clinics, medical group practices, home health agencies, and hospice facilities. Correctional treatment centers and state hospitals are exempt from this law and NPs at those facilities will continue to practice under standardized procedures.

Category 104 NPs – NPs in Their Own Practice

Practice Setting 104 NPs work in practice settings outside of those defined in Section 103, which means that an NP can open his or her own practice. The option for NPs to practice in these settings begins January 1, 2023. The new statute requires the Board to issue that certification to a nurse practitioner who meets additional specified education and experience requirements.

The ultimate outcome will establish a new category of nurse practitioners who meet certain education, experience, and certification requirements to perform specified functions without standardized procedures, including ordering, performing, and interpreting diagnostic procedures, certifying disability, and prescribing, administering, dispensing, and furnishing controlled substances.

The regulatory process to determine additional training and certification requirements is now currently taking place. These meetings are open and public comment via telephone is encouraged. If you are interested, you can find the NPAC meeting schedule here: www.rn.ca.gov/consumers/meetings.shtml.

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

Ask My Practice

by Andie Tena

Are You Billing Correctly for COVID-19 Vaccine Administration?

CAP's *My Practice* program has received several calls from CAP members about COVID vaccine reimbursement and denials, as there has been much confusion on how to bill. As if the pandemic hasn't been stressful enough due to income loss and other challenges, billing has become even more difficult to navigate.

The guidelines for billing for COVID vaccine administration vary based on payor type and if the physician is participating in the Centers for Disease Control and Prevention (CDC) COVID-19 Vaccination Program. Physicians who have opted to participate in this program have contractually agreed not to seek reimbursement from patients. However, health plans and insurers are required to reimburse for the administration of the COVID-19 vaccine regardless of whether the physician is in or out of network with the health plan.

Additionally, there are nuances in billing within each payor that may require a different way to submit claims than billers are accustomed to.

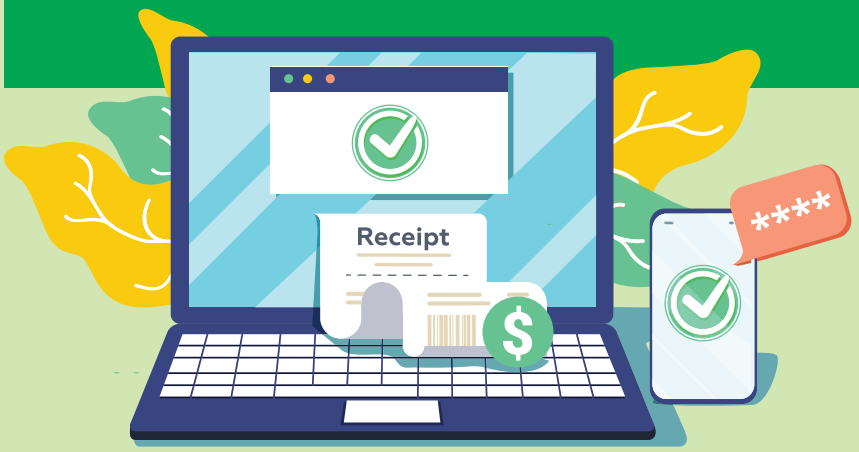
Fortunately, The California Medical Association (CMA) has created several helpful resources to address common issues related to billing and the COVID-19 vaccine. Visit **CAPphysicians.com/VaccineBilling** to view resources including:

- **CMA's COVID-19 Vaccine Reimbursement Quick Guide**
- **CMA Covid Vaccine Toolkit**
- **Additional Information from CMA and other sources**

My Practice is CAP's free practice management and business services solutions program. In addition to being available for general practice-related inquiries, *My Practice* can provide you with additional resources to navigate reimbursement and billing issues.

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

October 2021



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Update Your Membership Information to Help with Your Year-End Planning

October 2021

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- Retirement from practice at age 55+
- Part-time practice (e.g., 20 or fewer hours per week or 16 hours for anesthesiologists)
- Reduction or any change in the scope of your practice
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- Joining a practice insured by another carrier
- Moving out of state
- Termination of membership

The Board of Trustees of the Mutual Protection Trust will levy an assessment in November 2021. To allow ample processing time, we strongly recommend that you complete your Coverage Update Form (CUF) no later than October 31, 2021 to be evaluated for reductions or proration of the 2022 assessment.

The Coverage Update Form is available in the Members' Area of the CAP website at https://member.CAPphysicians.com.

If you have not yet registered for the Members' Area, please register for an account at **https://member.CAPphysicians.com/register**. You will need your member number and the last four digits of your Social Security Number.

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October 2021

IN THIS ISSUE

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.

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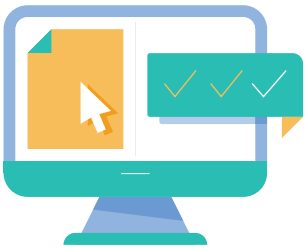

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[3] Some benefits details available in the Resources section of the enrollment portal or call to request. Pre-existing conditions exclusion applies (except for heart attack or stroke).
[4] Click on the Resources link to see a partial Schedule of Benefits for some covered conditions and more information upon request. Additional conditions and exclusions apply.
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Your Privacy with the Cooperative of American Physicians, Inc.

The Cooperative of American Physicians, Inc. (CAP) promotes a range of products and services designed with the welfare of physicians in mind. From the professional liability coverage provided through the Mutual Protection Trust (MPT) and the CAPAssurance Risk Purchasing Group (CAPAssurance) to the range of services and products offered through CAP and its affiliates, CAP's goal is to match healthcare providers with the best products and services — all tailored to fit their needs.

Information We Collect

When you join CAP, you provide us with pewrsonal information. We collect and use that information to service your needs at CAP, MPT, and CAPAssurance. We treat this personal information as confidential, limit access to those who need it to perform their jobs, and take steps to protect our systems from unauthorized access. The personal information we obtain falls into two general categories:

- Information we receive from you on the application and other forms you complete (e.g., first name, last name, organization, phone number, address, email, and CAP identification number) relating to:
  - CAP enrollment;
  - Professional liability coverage through MPT and/or CAPAssurance;
  - Other products and services available through CAP for which you request quotes or purchase
- Information about your transactions with CAP, MPT, CAPAssurance, and CAP's affiliates, including the CAP Physicians Insurance Agency, Inc. and the Cooperative of American Physicians Insurance Company, Inc.

Reasons We Share Your Information

We want you to feel secure about the non-public personal information you give to CAP. There are several reasons why we may need to share this information:

- For CAP's everyday business purposes – for example, to process your requests, maintain and service your records and accounts, administer CAP benefits and programs, and respond to court orders or legal investigations.
- For everyday business purposes of MPT, CAPAssurance, and CAP's affiliates.
- For CAP's marketing purposes with service providers we use, including affiliated group purchasing organizations and vendors – to offer our products and services to you.

To Limit the Sharing of Your Information

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