THE MONTHLY PUBLICATION FOR CAP MEMBERS

CAPsules®

COOPERATIVE OF AMERICAN PHYSICIANS

Case of the Month

Attending Surgeries With Limited On Call: Who Will Have Your Back?

This month, we feature an article from the archives written by CAP's former General Counsel Gordon Ownby

When attending to a weekend surgery at the hospital, make sure you don't find yourself all alone with too much to do.

A 61-year-old patient was the only scheduled surgery on a Saturday morning, where he was to undergo an ERCP for suspected inflamed gallbladder/bile duct gallstones. The gentleman had Type 2 diabetes, major depressive disorder, essential hypertension, and a remote history of a CVA. Dr. A, the anesthesiologist for the surgery, classified the patient as ASA III and anticipated a difficult intubation.

On the morning of the scheduled surgery, Dr. A—the only anesthesiologist on call at the hospital that weekend—learned that he was also to attend to a Cesarean section for a patient with failed labor.

The ERCP started at 8:15 a.m. that morning and after a difficult intubation, proceeded without incident. Surgery concluded at 9:25 a.m. but hospital staff notes at 9:35 a.m. showed the extubated, bag-masked patient in the PACU as unresponsive. Dr. A ordered new dosages of relaxant-reversals without improvement. Dr. A then re-administered a muscle relaxant and attempted to re-intubate the patient. When the reintubation failed, Dr. A was successful in placing a laryngeal mask airway (LMA). At 10:00 a.m. with the LMA in place and connected to a ventilator, Dr. A left the patient in the care of the nursing staff and respiratory therapists as he began general anesthesia for the Cesarean section in the OR next door.

With Dr. A at the Cesarean section, the GI patient desaturated and staff called the emergency room physician, who arrived at 10:05 a.m. According to his records, the ER physician noted no breath sounds or chest rise. The ER physician asked the staff to call Dr. A back to the PACU stat to re-establish an airway and to call any other available anesthesiologist—as well as a general surgeon in the event of a cricothyrotomy. The ER physician made several unsuccessful attempts to intubate the patient and began an emergency cricothyrotomy when Dr. A returned to the PACU. The ER physician asked Dr. A to assist in establishing an airway, but Dr. A stated he did not think he could do that successfully as he had previously been unable to re-intubate the patient and that he needed to return to the Cesarean delivery. The ER physician unsuccessfully attempted the cricothyrotomy and a Code Blue was called at 10:22 a.m. Another anesthesiologist arrived at 10:40 a.m. and successfully intubated the patient. The patient remained pulseless, however, and was declared dead at 11:07 a.m.

September 2022

continued on page 2

Continued from page 1

In a subsequent lawsuit, the family sued Dr. A for medical negligence and for patient abandonment. Dr. A and the family resolved the litigation without going to trial.

In his deposition, Dr. A testified that he advised the OB surgeon to speak to the GI surgeon regarding whether the Cesarean delivery could be performed first. No such change occurred. Dr. A also testified that staff was unable to get another anesthesiologist to take the Cesarean section or to get a surgeon for a possible cricothyrotomy.

Jurors expect physicians to make more than just technical medical decisions: When a situation puts patient safety at risk, they will look for a physician's assertiveness. These are the times for the "patient's advocate" to be heard.

Risk Management and Patient Safety News

September 2022

Identifying, Understanding, and Unlearning Implicit Bias

by Monica Ludwick, Pharm. D

We know you always have your patients' best interests at heart. But have you thought about the possibility that unconscious biases against certain genders, ethnicities, or cultures may be impacting your care?

A bias is the negative evaluation of one group and its members relative to another. Implicit or unconscious bias does not require an individual to be aware of their actions or beliefs.

It has been well documented in literature and studies that implicit bias in healthcare can directly lead to healthcare disparities. This concern continues to be a topic of nationwide attention, and has been a target goal in the Department of Health and Human Services Healthy People 2000 and 2010 initiatives.[1,2] In Healthy People 2020 it was highlighted as a major continuing challenge.[2] The National Institute of Health has prioritized eliminating healthcare disparities in its top five initiatives and has encouraged healthcare practitioners to consider how biases, stereotypes, and discrimination may contribute to such disparities.[3]

Almost 20 years ago, inequities in healthcare came to light in the Institute of Medicine (IOM)'s "Unequal Treatment" report written by a panel of physicians, public health experts, and behavioral scientists. The panel reported that racial and ethnic minorities received inferior healthcare more often than non-minorities, even when access to healthcare barriers such as insurance and income did not exist.[3] Some of these affected groups include:

- Minority ethnic populations
- Immigrants

continued on page 3

Continued from page 2

- The poor
- Low health-literacy individuals
- Sexual minorities
- Children
- Women
- The elderly
- The mentally ill
- The overweight
- The disabled

Implicit bias has influenced trends in healthcare[3] which include:[4]

- Non-white patients receive fewer cardiovascular interventions
- Black women are more likely to die after being diagnosed with breast cancer
- Patients of color are more likely to be blamed for being passive with their healthcare
- Heterosexual healthcare professionals have a moderate to strong preference for treating heterosexual people over gay and lesbian patients[5]
- Fat shaming, which has proven ineffective for driving motivation, adversely impacts the patient experience[6]

Examine Your Own Biases

An important step in combating implicit bias is self-examination. Can you confidently say you have never made an assumption about a patient based on his/her/their appearance or other basic traits? We all have at one point or another quickly and automatically labeled people based on social or other demographic characteristics. Unfortunately, these actions are also the basis for stereotypes, prejudice, and ultimately, discrimination.

There are many tools available for use to examine your own possible biases. The Implicit Association Test (IAT) measures attitudes and beliefs that people may be unwilling to report. The IAT measures relationships between different concepts (e.g., gender/ethnicity) and your subconscious assessment (e.g., good/bad). Various IATs are available, including those for gender, ethnicity, sexuality, and more. Although the IAT is subject to controversy due to the lack of reproducibility and the question of what it measures, it can shed a light on what we may be closing our eyes to.[7]

Implicit bias is pervasive even if people differ in levels of such bias. People are often unaware of their implicit bias and that it predicts behavior.

As biases become recognized, healthcare providers can look for resources, strategies, and skills to minimize and prevent such unconscious and unintentional attitudes and stereotypes from negatively influencing the course of treatment and evaluations of certain groups. Whether it is a patient or a physician who brings prejudice into the healthcare setting, it can strain the doctor-patient relationship, even if the treatment is not impacted.[8]

Strategies to better care for patients of diverse backgrounds:

- Focus on the characteristics of each patient, rather than their group identity
- Aim to interact and discuss issues with colleagues and patients with diverse backgrounds and experiences
- Approach patients with empathy and focus on their perspective (put yourself in their shoes)

How can I combat biases and stereotyping?

- **Be aware and point it out.** Catch yourself when making negative preconceptions and openly talk about it
- **Be an example.** Be a role model and respect people regardless of what stereotypes may exist
- **Speak up.** Engage people around you to reflect and engage in open conversations

continued on page 4

Continued from page 3

Be Educated

The California legislature recognized the link between implicit bias and strong racial disparities in maternal mortality and morbidity. Since 2021, California requires its hospitals to educate their perinatal care staff about implicit bias.[9] Implicit bias training is also required for new nursing graduates.[10] Effective January 1, 2022, implicit bias is required to be included in Continuing Medical Education Activities and programs.[11]

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

References:

[1]Blair IV, Steiner JF, Havranek EP. Unconscious (Implicit) Bias and health disparities: Where do we go from here? Perm J. 2011; 15(2):71-78.

[2]https://health.gov/our-work/national-health-initiatives/healthy-people/healthy-people-2020

[3]FitzGerald C, Hurst S. Implicit bias in healthcare professionals: A systematic review. BMC Med Ethics. 2017;18:19.

[4]Implicit bias in healthcare. Quick Safety. The Joint Commission. April 2016; 23.

[5]Sabin J, Riskind RG, Nosek BA. Health Care Providers' implicit and explicit attitudes towards lesbian Women and gay men. American Journal of Public Health. 2015;105(9), 1831-1841.

[6]"Sizeism is a Health Hazard" Joan C. Chrisler, Ph.D. Angela Barney, M.A. Connecticut College, New London, CT. Poster presented at the 29th APS Annual Convention, 2017.

[7]Maina IW, Belton TD, Ginzberg S, Singh A, Johnson TJ. A decade of studying implicit racial/ethnic bias in healthcare providers using the implicit association test. Soc Sci Med. 2018 Feb;199:219-229. Epub 2017 May 4.

[8]Gainsburg I, Derricks V, Shields C, Fiscella K, Epstein R, Yu V, Griggs J. Patient activation reduces effects of implicit bias on doctor-patient interactions. Proc Natl Acad Sci U S A. 2022 Aug 9;119(32): Epub 2022 Aug 1.

[9]https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=201920200SB464

[10]https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB1407 nursing

[11]https://leginfo.legislature.ca.gov/faces/billCompareClient.xhtml?bill_id=201920200AB241&showamends=false

Save the Date

Saturday, October, 2022

9:00 a.m. to Noon

Fall Litigation Education Retreat

Supporting CAP Members During a Medical Professional Liability Lawsuit

Supporting CAP Members During a Medical Professional Liability Lawsuit

Whether you are in the process of a medical professional liability lawsuit, or simply interested in learning more about the litigation process, the Cooperative of American Physicians' Litigation Education Retreat can provide valuable support and guidance.

During this virtual, interactive event, you will learn techniques to help you secure the most favorable litigation result and alleviate the anxiety that most physicians experience during this exceptionally stressful time. Participants who attend this live virtual event will earn three CME* AMA PRA Category 1 Credit(s)™

Register at **www.CAPphysicians.com/OctLER**

The Rocky Path to Prior Authorization Reform

by Gabriela Villanueva

The call for comprehensive prior authorization reforms continues to be a leading issue among healthcare providers. In 2018, six national healthcare advocacy associations released a Consensus Statement outlining recommendations for reforming prior authorization, **https://www.ama-assn.org/practice-management/prior-authorization/prior-authorization-reform-initiatives** At its core, prior authorization is an insurer's utilization management program intended to evaluate the efficiency, appropriateness, and medical necessity of the treatments and services its members receive. Of course, the standard of care may vary by specialty, geography, or other factors not accounted for in policy making. Healthcare providers must continuously navigate prior authorization requirements, which can cost significant amounts of time and practice resources and affect patient care.

In December 2021, the American Medical Association (AMA) surveyed 1,000 practicing physicians about their experience with prior authorization.

Survey Highlights

- 88% of respondents reported that prior authorization generates high or extremely high administrative burden for their practices.
- Practices complete an average of 41 prior authorizations per physician per week and spend an average of almost two business days a week completing prior authorizations.
- 40% of respondents reported that they have secured additional staff to work exclusively on prior authorization, including keeping up with varied requirements across payers.
- 93% of physicians reported that prior authorization led to delays in patient care at least some of the time.
- 34% of physicians said prior authorization issues contributed to a serious adverse event for a patient in their care.

This recent survey data confirms that prior authorization issues continue to pose significant challenges for both physicians and patients, and that many of the recommended reforms in the Consensus Statement a few years ago have yet to be widely implemented by health plans. The COVID-19 pandemic created additional challenges for prior authorization and further highlighted the need for a legislative solution.

During the 2021-2022 California legislative cycle, Senator Richard Pan (D-Sacramento), introduced SB 250 to attempt to address the prior authorization issue and alleviate some of the administrative burdens placed on physicians.

SB 250 would:

- Prohibit a healthcare service plan (health plan) or health insurer, on or after January 1, 2024, from requiring a contracted health professional to complete or obtain a prior authorization for any healthcare services if the health plan or insurer approved or would have approved not less than 90% of the prior authorization requests they submitted in the most recent one-year contracted period.
- Establish standards for this prior authorization exemption and its denial and appeal.
- Authorize a plan or insurer to evaluate this exemption not more than once every two years.
- Prohibit a plan or insurer from rescinding an exemption outside of the end of the two-year period.

As of late August, with only a few days left before this year's session adjourns, SB 250 had been stalled in the Assembly Appropriations committee, short of the necessary votes to move on to a full floor vote in the Assembly and out of time to reintroduce in its same form in the 2023 legislative session.

Meanwhile in July 2022, Congressional legislators in the House Ways and Means Committee unanimously advanced the Improving Seniors Timely Access to Care Act of 2022. Meant to put guardrails on Medicare Advantage (MA) plan prior authorization requirements, the bill would increase transparency around MA prior

continued on page 6

Continued from page 5

authorization requirements, standardize the prior authorization process for routinely approved services, and establish an electronic prior authorization program. Although not yet passed, this bill had immense support, including 280 cosponsors, a Senate companion bill, and endorsement from almost 400 organizations across the healthcare industry.

Although no concrete solutions have yet been reached, and while congressional efforts are narrowly tailored to the MA population, it is worth noting that there are now 28 million Medicare beneficiaries and counting enrolled in MA plans. As opposed to a patchwork of state laws on the issue of prior authorization (as we are experiencing with No Surprise Billing), federal reforms implemented at the MA level can ultimately lead to similar reforms industry wide, and achieve greater uniformity in PA practices.

2021 AMA Survey- **https://www.ama-assn.org/system/files/prior-authorization-survey.pdf**

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

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

September 2022

If you are considering a change in your practice this year or in 2023, please notify CAP as soon as possible so our Membership Services Department can review your options with you and make your coverage transition a smooth one. Changes include, but are not limited to:

- 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
- Employment with a government agency or nonprivate practice setting
- Employment with an HMO or other self-insured organization
- 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 2022. To allow ample processing time, we strongly recommend that you complete your Coverage Update Form (CUF) no later than October 31, 2022, to be evaluated for reductions or proration of the 2023 assessment.

The online Coverage Update Form is now available in the Member's Only Area of the CAP website at **https://member.CAPphysicians.com**.

If you have not yet registered for the Member's Only 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.

For assistance, please call Membership Services at **800-610-6642** or email **MS@CAPphysicians.com**.

Ask My Practice

by Andie Tena

The Advancing Telehealth Beyond COVID-19 Act

On July 28, 2022, The House of Representatives voted 416-12 to pass the Advancing Telehealth Beyond COVID-19 Act, legislation that would continue Medicare patient access to telehealth services, including audio-only services, **through 2024**. The telehealth extension bill will allow telehealth visits to be covered after the public health emergency (PHE) ends.

The PHE was originally declared in January 2020 and has been extended numerous times since its activation. The PHE is currently scheduled to end on October 13, 2022 (https://aspr.hhs.gov/legal/PHE/Pages/covid19-15jul2022.aspx) but could be renewed for another 90 days. At the time of this article's writing, it is unclear if the PHE will be renewed for another 90 days; however, in the omnibus spending bill passed this past March, Congress granted a five-month (151 days) extension to telehealth waivers created during the pandemic. The 151-day extension would begin at the end of the public health emergency (PHE).

According to the bill, the Act provides flexibility beyond the 151 days and ensures the following telehealth services and coverage continue through December 31, 2024:

- Payment for certain telehealth visits, including some audio-only visits
- Allowing all all Medicare-enrolled providers to bill for telehealth services
- Extending originating site and geographic restriction flexibilities
- Delay of in-person requirements for virtual mental health services for Medicare patients until 152 days after the expiration of the PHE
- Expansion of practitioners eligible to provide telehealth services to include occupational therapists, physical therapists, speech-language pathologists, and qualified audiologists
- Temporary payment policies for rural health clinics and Federally Qualified Health Centers (FQHCs)

continued on page 8

Continued from page 7

TOPIC	FLEXIBILITY	EXPIRATION DATE
MEDICARE TELEHEALTH	Originating site and geographic restrictions	151 days after declared end of the COVID-19 PHE
	Qualifying providers eligible to furnish telehealth	
	Coverage of audio-only services	
	Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) furnishing telehealth	
	Behavioral and mental health in-person requirements	
	Waived HIPAA penalties for technology used to furnish telehealth	Expiration of PHE
	State licensure requirements to furnish telehealth in other states	State specific; some currently expired, others tied to expiration of PHE

Courtesy of MGMA August 2022, Government Affairs

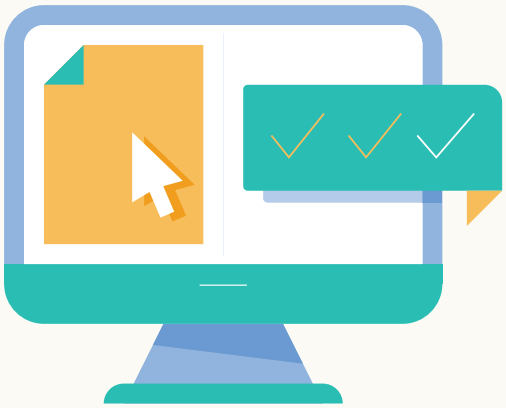
https://www.mgma.com/getmedia/0469e634-1990-4dd9-8326-e845174f1fe3/08-16-2022-PHE-Expiration-Resource.pdf.aspx?ext=.pdf

As of this writing, a vote is still pending in the U.S. Senate to get the bill to President Biden's desk for this signature.

If you are not currently using telehealth and are interested in learning more, please contact Andie Tena, Director of Practice Management Services at CAP, **ATena@CAPphysicians.com**, **213-473-8630** or visit **https://telehealth.hhs.gov/**

Andie Tena is CAP's Director of Practice Management Services. Questions or comments related to this column should be directed to ATena@CAPphysicians.com.

2022 Open Enrollment: How to Take Advantage of Exclusive Personal Insurance Coverage at Excellent Group Rates



CAP Physicians Insurance Agency , Inc. (CAP Agency) is pleased to announce the upcoming 2022 open enrollment period when CAP members will have the exclusive opportunity to access a wide range of personal insurance products and flexible plan options at competitive large group rates.

Open enrollment will occur this year from October 1st through November 15th for coverage beginning January 1, 2023.

Open enrollment **is only scheduled once a year for a limited time**, so this will be your best chance to take advantage of the excellent benefits CAP Agency has to offer members through MetLife at low group rates.

The following products will be available for you to upgrade your existing benefits or purchase new coverage.

Short Term Disability[1]	$1,000 weekly benefit plan in addition to state disability benefits.
Long Term Disability[1,2]	Up to a $10,000 maximum monthly benefit[2] available or 60% of your income.
Life Insurance (Medical Underwriting Required for New Policyholders[3])	Up to a $500,000 death benefit paid directly to the beneficiary tax-free.
Accident Insurance[1]	Affordable coverage for unforeseen bills after an accident or injury, especially if you have a high deductible health plan or limited network.
Critical Illness Insurance[1]	Protection from the financial impact of a critical illness such as cancer diagnosis, heart attack, or stroke.
Hospital Indemnity Insurance[1]	Coverage to help pay for expenses, such as hospitalization admission and confinement, that may not be covered under your medical plan.
Dental and Vision[1] (purchased separately)	Flexible plan options available for physicians and their family members.

continued on page 10

Continued from page 9

New Offerings

Legal Plans	Access to experienced attorneys to help with estate planning, home sales, tax audits, and more.
Identity & Fraud Protection	Fraud protection, digital security, and identity theft protection, all under the same plan.
Pet Insurance	Helps cover the costs of vet visits, accident, illness, and more.

Save the date and prepare now:

1. Review your current policies and benefits.
2. Assess your current personal and business needs and any major changes within the past year.
3. Collect required information: Social security numbers, beneficiary information, birthdates, etc.
4. Review available coverage programs at **www.CAPphysicians.com/business-and-personal-insurance**.

Our goal is to ensure that all CAP members have a comprehensive overview of their available benefits so you can make informed decisions on what kinds of coverage are best for you, your family, and your practice for the coming year.

More information about the open enrollment period will be available in October. Do not miss important emails from CAP that will include details on rates and enrollment. Contact us today at 800-819-0061, or at CAPAgency@CAPphysicians.com for questions about your current coverage or anticipated coverage needs.

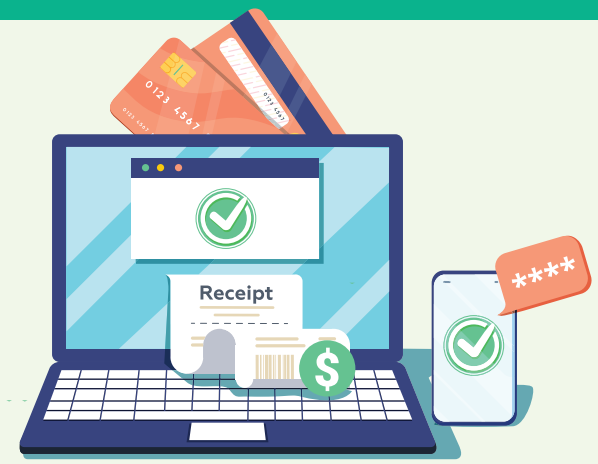
[1]To be eligible, you must be working in healthcare at least 17.5 hours/week and cannot be currently disabled or at the time coverage becomes effective. Other limited time preexisting condition exclusions may apply.

[2]Income from the tax year immediately prior will be used to determine benefit at time of claim.

[3]Members covered by CAP longer than 90 days and not previously enrolled in supplemental life coverage.

CAP PHYSICIANS INSURANCE®
License No. 0F97719

September 2022



Go Paperless and Enroll in Autopay Online to Manage Your CAP Bill Conveniently and Securely

There has never been a better time to manage your CAP bill online and make automatic payments directly from your checking account.

Starting January 2023, CAP members who receive their printed monthly statements via postal mail will automatically be enrolled in paperless billing to help reduce costs and paper waste on behalf of the entire membership. *(There will be the option to continue receiving paper bills for a $2 monthly fee.)*

You don't have to wait until January to go paperless. With paperless billing, you can receive access to your statements via email, set up automatic payments using your checking account, and manage your account easily through a secure portal.

Cut Down on Paper and Hassle

If you are still paying your CAP bill by paper check, consider making your payments by recurring ACH transactions, which debits funds from your checking account just like a paper check but with a lot less hassle. Even if you pay your CAP bill automatically with a credit card, switching to ACH payments may be a better option.

Three reasons to go paperless and set up auto pay payments from your checking account:

1. **Faster processing time:** With ACH, there is no need to write and mail your check and wait for it to clear. There is also no need to constantly update credit card numbers.
2. **Secure and reliable:** No more worrying about having your check stolen or lost in the mail. Electronic payments are secure and reliable.
3. **Save time and money:** Not only will you save on the cost of stamps, checks, and envelopes, you can save yourself the time and effort waiting for your bill and payment due date.

Enroll in paperless billing and set up automatic payments today!

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.
3. Select the **"Via Email Only"** button.
4. Verify your email address and click the **"Save Changes"** button.
5. Then, simply click on the **"Pay CAP Bill"** button (Agree to the terms and conditions when prompted) and follow the instructions to set up autopay payments by clicking on the **"Set Up Autopay Payments"** and provide the required information for recurring payments made by ACH.

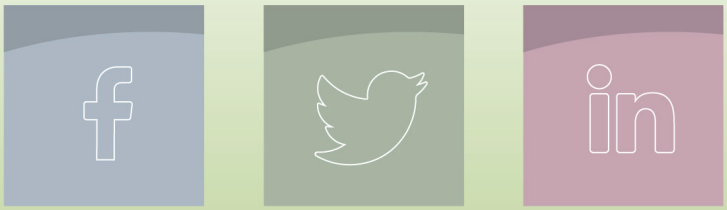
For assistance with your account or if you have questions about your membership, please call **800-610-6642** or email **MS@CAPphysicians.com**.

September 2022

COOPERATIVE OF
AMERICAN PHYSICIANS

Cooperative of American Physicians, Inc.
333 S. Hope St., 8th Floor
Los Angeles, CA 90071

Connect with CAP on Social Media!



September 2022

IN THIS ISSUE

333 S. Hope St., 8th Floor, Los Angeles, CA 90071 | 800-252-7706 | www.CAPphysicians.com.

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.