



## How do you thank someone for saving your life?

This month, our "Member Profile" column features a heartwarming story about two CAP members and their remarkable friendship. Dr. Colleen Coleman has been a CAP member since 2006, and Dr. Brian Dunn has been a CAP member since 2004. The following article is reprinted with permission and originally appeared in the February 27, 2017 edition of The Orange County Register.



How do you thank someone for saving your life?

Brian Dunn, 45, an anesthesiologist who got a new kidney on Jan. 30, sat down and wrote an email, the most important email of his life.

It needed to convey how his donor had given him the gift of time: Time to be a good dad to his 7-year-old daughter, time to be a good husband, time to be a good doctor with a new sense of compassion for patients who are just as vulnerable as he had been.

Colleen Coleman, 51, a surgeon who donated her kidney to Dunn, got emotional when she received Dunn's email. They had been friendly for more than a decade, working across the operating table from each other, but never friends. Now, they are forever connected by her kidney.

"That letter was very touching to me," she said.

Then the other letters arrived – a letter from Dunn's wife, a letter from his mother.

When she got back to work at Hoag Hospital Newport Beach, the hallway was lined with streamers. There were flowers, a cake, and so many people calling her a hero.

"I did not understand how impactful it would be to help someone in this way," Coleman said. "There is a benefit to giving. But hero is a very embarrassing word."

She almost wasn't a hero at all.

### Movie music

Drs. Dunn and Coleman, who went to Irvine High, met in 2003. He remembers the first time. He brought music into the operating room. If she got to pick, she would love to hear heavy metal – "Metallica," she said. But Dunn brought in theme songs from movies.

He played music from "Superman," "Batman" and "Raiders of the Lost Ark." He would ask her to name the film.

"She knew her movies," Dunn said. "That was our connection."

What she didn't know was how sick he had been, and how his illness had changed his life.

### History of trouble

When he was 16, Dunn got a stomach ache after a track meet. He grew up in Menlo Park, in Northern California, where, as a teenager, he had been a budding track star. Dunn went to the doctor, who discovered a large tumor in his stomach, and an enlarged testicle.

Brian Dunn felt doomed. "The doctor told me I had less than a 1 percent chance to live," Dunn said. "He told us to consider hospice care."

"My father cried for the first time I had ever seen him cry," Dunn said.

But his parents did research and found him a miracle. They took him to Indianapolis, where he had a new kind of

*Continued on page 2*

chemotherapy, which had a different mix of drugs than he had been using in Menlo Park.

The chemo saved him, but it cost him dearly. It ruined his kidneys.

Dunn was the valedictorian of his graduating class. He went to Stanford, then medical school at UC Irvine. He decided to become an anesthesiologist, knowing his immune system had been compromised. He would try to stay away from unknown, communicable diseases.

When was 25, he took a physical and found that his kidney was failing.

His mother, Judith, stepped up and donated her kidney without hesitation.

"When your mother does that, you better come home for Christmas," Dunn said.

Donated kidneys, Dunn said, can last a couple of decades.

## 20 years later

In October of 2015, Dunn could feel his health slipping away. He had become an anesthesiologist at Hoag, bouncing from hospitals in Newport Beach and Irvine.

"I started dragging," he said. "Holy crap, I felt bad."

He and his wife, Dianne, had adopted a daughter (conceiving a child was another cost of chemotherapy), and he was having a tough time keeping up with then 6-year-old Caroline.

In April of 2016, he started dialysis, which he called "my prison." He had to have his system washed out four times per day. It zapped his time and his strength.

He needed another transplant. At first, his chances looked promising. A woman in Ladera Ranch, where he lived with his family, had been tested and was a match for Dunn.

But she backed out of the surgery.

"I thought, it's not going to happen," Dunn said.

Around that same time, Colleen Coleman had heard that Dunn needed a donor. She had worked, as a young medical student, on the "harvest team" at UCLA. For three years, she had worked with recipients of organ donations.

One day in the operating room, Coleman looked across at Dunn, who was looking sick. She asked him, "What blood type are you?"

He was A-negative.

"Me too," she said.

## Second thoughts

Coleman went home that night and asked her husband, Dr. William Wallace, an obstetrician-gynecologist, what he would think if she donated a kidney.

"I wouldn't give up one of my kidneys," he said.

"I'm giving up one of mine," she said.

Here's the problem, Coleman wasn't a match for Dunn. At least that's what the testing company told her.

She admitted she was relieved. Though she has been a surgeon, the thought of going under the knife scared her.

So Dunn kept hoping. He found another match, a patient suffering from Amyotrophic Lateral Sclerosis (Lou Gehrig's disease). His doctor advised him not to take that kidney.

Then, last June, the testing company called back and said it had made a mistake. They re-tested Coleman and found she was a match.

Dunn said his first reaction was to feel guilty because he would be putting Coleman through such pain.

She could have stopped the process there. She considered backing out.

"You should have second thoughts," Coleman said.

"What if I died in the process?"

But she thought about her grandmother, who died of kidney failure. Coleman's mother had been 6 when her mother died. Brian Dunn's daughter then was 6.

"I didn't want his daughter to grow up without a dad," Coleman said.

Coleman organized a dinner so her husband and two children could meet Dunn, his wife and his daughter. Her husband changed his attitude after meeting Dunn.

"You better follow through," he said.

## Transplant day

Dunn gave Coleman a set of Tiffany earrings, each in the shape of a kidney.

Coincidentally, Coleman gave Dunn a Tiffany money clip in the shape of a kidney.

When the transplant was over, Coleman went to see him.

"I wanted to make sure my kidney could pee," she said.

As it turned out, everything went as planned. Three weeks after the surgery, Dunn said he is feeling as vibrant as he is grateful.

So what did he write in that letter? Here is just a part:

*"I am so excited about what a new kidney will mean to my life. First and foremost, it will greatly prolong my life. I've been told that every year on dialysis takes three years off your life. The transplant list in California is about 15 years long – 15 years of dialysis wouldn't leave me much life even if I eventually got one through that route. The most distressing part of this process was thinking of my 7-year-old daughter, Caroline, growing up without a father. She's a tough kid, but she's also a*

*'daddy's girl.' I need to be there for her. And this kidney will help that be possible ...*

*"It's hard for me to rely on other people. I usually try to get through problems on my own - I guess I have some trust issues. I'm also a bit of a 'people-pleaser.' I want to be seen as self-sufficient and not a burden to anyone ... You got re-tested after they said you weren't a match the first time. You got all kinds of medical testing done to prove you could give a kidney. After a 9-month process, the procedure is going to happen. And it is largely due to your hard work and perseverance ...*

*"Monday, January 30th is a day I'll remember forever. It's the day that someone did something truly selfless for me. Colleen, you are an answer to prayer and an amazing example to everyone around you.*

*"Thank you for your sacrifice." ❖*

## The Tangling of Bundled Payments

As the political debate over repealing and replacing "Obamacare" persists, the Affordable Care Act (ACA) itself set off a number of important changes across multiple agencies and industries -- changes that seven years on, continue to shift and reshape.

Probably more than any other federal agency, the Centers for Medicare & Medicaid Services (CMS) has undergone the most significant shifts as it is the agency responsible for delivery and payment of healthcare for millions of patients across the country.

With the passage of the ACA, Congress created the CMS Innovation Center (CMMI) and charged it with testing "innovative payment and service delivery models to reduce expenditures . . . while preserving or enhancing the quality of care." With that mission began the shift from a fee-for-service model to a valued-based reimbursement model. As a result, physicians and other healthcare providers have had to test a variety of different payment and service delivery models developed by CMMI and implemented by CMS.

Of the multiple programs developed over the past seven years, the bundled payment model, called the Bundled Payments for Care Improvement initiative (BPCI), has been the most widely implemented as commercial insurers have been quick to offer bundled reimbursement programs. But the program hasn't been without controversy because

of CMS designating some bundled programs as voluntary, while making others mandatory. It is widely known that the new Health and Human Services Secretary Tom Price strongly opposes mandatory bundled payments and, in general, Republicans in Congress disfavor CMMI's mandatory initiatives, as shown in a letter signed by 179 Republican members last September accusing CMS of overstepping its authority by imposing a mandate without Congressional approval.

Consequently, it is not surprising that on March 21, CMS announced a delay in the implementation of its recent rule creating a mandatory bundled payment program for cardiac care and in the expansion of a major payment pilot, the Comprehensive Care for Joint Replacement (CJR), from July 1, 2017 to October 1, 2017. Effective dates for final rules on CJR also were pushed back from March 21, 2017 to May 20, 2017.

If these delays reflect the priorities of the new administration, physicians should watch Secretary Price's actions in this arena for any indication of a major new approach to bundled payments. Meanwhile, as bundled payment models become more widely implemented, they will likely shift to conform to the definition of advanced alternative payment models (APMs), as outlined in MACRA. ❖

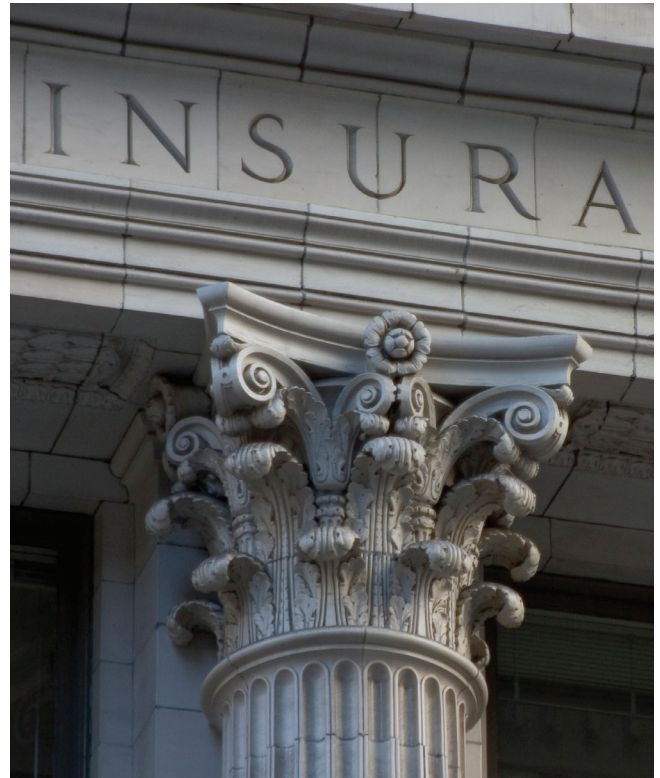
**CMS Link:**  
<https://innovation.cms.gov/initiatives/bundled-payments/>

# Protections Against Employment Practices Liability

Every business that acts as an employer has the possibility of exposure to lawsuits from employees or former employees. We hear from our doctors, "My employees love working here. They would never sue me." The reality of running a business is everyone who employs workers runs the risk of being sued. Companies such as medical practices do not always have defined Human Resources policies and procedures, which leave them more vulnerable to litigation.

As an employer, you can put in place protections against employment practices lawsuits by implementing the simple steps below, which may help prevent a lawsuit or claim in the future and help protect your practice from potential financial hardships.

- Incorporate a Human Resources Manual/Employee Handbook specific into your practice with clear policies and procedures. It is important the handbook contains the business's equal employment opportunity policy as well as an internal mechanism to complain about discrimination or harassment. You can download a customizable Human Resources Manual on the CAP website under the member only section of [www.CAPphysicians.com](http://www.CAPphysicians.com).
- Train supervisors in Human Resources procedures and policies and keep all policies in one place.
- Provide employee handbooks to all new employees and review policies and procedures with all new hires as part of an employee orientation.
- Keep your policies up to date when there are changes in the law. Be sure your Human Resources Manual reflects these changes.
- Prior to terminating an employee, or if an employee has issues with wage and hour, leaves of absence, discrimination allegations, employee misconduct, and/or performance policies, contact the CAP Human Resources Hotline at 213-473-8664.
- Purchase an Employment Practices Liability policy to protect against any claims brought against your practice.



On average, 81 percent of Employment Practices Liability claims settle for between \$22,000 and \$40,000, a significant amount for a small business. CAP physician members have a \$50,000 defense-only benefit provided by your Employment Practices Plan (EPP), with a \$5,000 deductible for individual members. This EPP plan would not pay for any settlements, fines, or penalties. As you can see from the above examples, this benefit would help, but probably not cover all the costs a claim may bring.

CAP Physicians Insurance Agency, Inc. (CAP Agency) has competitive rates for EPLI coverage available for our doctors. You owe it to yourself and your practice to get a quote. We at the CAP Agency stand ready to help you protect your practice. Contact us at 800-819-0061 or email us at [CAPAgency@CAPphysicians.com](mailto:CAPAgency@CAPphysicians.com) for more information. ➦



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# Keeping You Current on MACRA and HR Compliance: Two New Practice Management Resources Free for the Asking

MACRA is here. While the Centers for Medicare & Medicaid Services (CMS) adjusted flexibility for the first year of participation in MACRA, recent surveys indicate that most smaller practices are unprepared for the changes that will occur next year. CAP is committed to providing comprehensive resources to the independent physician to help you navigate these regulatory updates, including information on MIPS – the Merit-based Incentive Payment System. (CMS estimates that roughly 90 percent of providers subject to MACRA will participate in MIPS.) Our comprehensive MACRA Resource Page features the latest updates and resources, including our brand new MACRA white paper. You can access these valuable resources and sign up for updates at [www.CAPphysicians.com/MACRA](http://www.CAPphysicians.com/MACRA).

When was the last time you updated your practice's HR Manual? If the answer is, "Not recently enough," then you'll want to download CAP's 2017 HR Manual. Specifically written for medical practices and fully customizable, this comprehensive manual includes policies relevant and necessary for a practice of your size. An updated HR Manual helps with compliance with federal and state laws, and is an invaluable tool for practices with little or no dedicated HR support. This HR manual is just one of the many free HR-related benefits available to you as CAP member. You can download the manual and view a list of your HR support benefits at [www.CAPphysicians.com/HRsupport](http://www.CAPphysicians.com/HRsupport). ➦

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# CAP CEO Sarah Pacini Elected Chair of the Captive Insurance Companies Association (CICA)

CAP Chief Executive Officer Sarah E. Pacini has been elected Chair of the Board of Directors for the domicile-neutral Captive Insurance Companies Association (CICA). She assumed her new role, succeeding Michael Bemis, March 15, 2017.



Ms. Pacini, who has been a CICA board member since 2013 and has previously served as its vice chair, was elected by the board in recognition of her continued meaningful strategic contributions to the association. As chair, Ms. Pacini will work in collaboration with board members and incoming CICA president Dan Towle to advance the organization's strategic direction while remaining apprised of new developments in the regulatory, compliance, and program design arenas. She also will act to ensure that CICA delivers on its mission of providing superior education, advocacy, and leadership to its members.

Ms. Pacini brings to her new role as board chair a wealth of expertise in the fields of healthcare, law, patient safety, captive insurance, claims and risk management, as well as medical professional liability coverage. In her ongoing role as CEO of CAP, she has since 2015 worked in conjunction with its physician leaders to effectively establish, refine, and direct enterprise strategies, objectives, and goals. She also has been instrumental in advancing the organization's mission and helping it remain current and informed during a period of unprecedented industry change. Additionally, Ms. Pacini serves as chief executive officer of the Cooperative of American Physicians Insurance Company, Inc. (CAPIC).

"This is a time of maturation for the captive insurance industry, and it is characterized in equal measure by great opportunities and notable challenges," said Ms. Pacini. "I am pleased to be in a position to lead CICA into the future and help members navigate the path ahead, ensuring that the organization remains vibrant, relevant, and of optimal value to them."

Ms. Pacini also has been reelected to an additional three-year term on the CICA board. She is a graduate of Purdue University School of Nursing and earned her Juris Doctor degree (Summa Cum Laude) from DePaul University College of Law with a Certificate in Health Law. ➦



*Sarah E. Pacini, CAP Chief Executive Officer*



# The Successful Physician

by Carole A. Lambert, MPA, RN

## Who Cares?

### Caring for the Caregiver: The Fourth Principle in the Quadruple Aim

The Triple Aim – enhancing patient experience, improving population health, and reducing costs – has been widely adopted as a set of principles for reform not only in the U.S., but also within many organizations around the world. The successful achievement of the Triple Aim requires a highly effective organization with an engaged and productive workforce – clinicians and staff who have found meaning in their work and a sense of accomplishment regarding their contributions. Recognizing that more and more is expected – if not demanded – of clinicians and staff, it has been urged that we modify the Triple Aim to the Quadruple Aim and add improving the experience of providing care as the Fourth Aim.

Reflecting on the Quadruple Aim, we see parallels in the patient, physician, staff, and organizational trajectories, which are traveling through an environment of regulatory demands, financial constraints, and human fallibility.

We search for meaning in receiving and providing healthcare. Why has the treatment or medication been ordered? Why does it matter? Who will it affect? What will it cost? Will it change anything? What do we hope for? What do we fear? The work has meaning beyond the task – a shared understanding of the work is a bond among physicians, patients, staff, and organizations.

We want a sense of accomplishment – that we are acting rather than reacting, taking steps, making changes. Calling on our experience and expertise, being focused

but flexible in responding, we are constantly learning, setting a tone of partnership among the members of the healthcare team.

We hope for a feeling of belonging – for identity, respect, courtesy, reliability, predictability – for safety. We want to be seen, known, listened to. We would like as few surprises as possible – unless they are really good surprises! We would like people to do what they say they will do.

The challenge to physicians, patients, staff, and organizations is to work together to create and maintain a healthy supportive workplace in the area, however small or large, that we manage. We are unavoidably joined together in this enterprise, using the resources at hand to care for and protect physicians, patients, staff, and the organization.

We can begin by ensuring that we are mobilizing communication in all its forms, providing information and education to empower and hold accountable, and receive feedback from every member of the team. We can set standards of performance and behavior and provide patient education and staff training and development to implement and reinforce them. We can be relentless in our attention to detail to an ongoing critical evaluation of systems and to their consistent implementation.

In such a dynamic environment, physicians, patients, staff, and organizations can share a sense of pride in their care of and for each other, making the Quadruple Aim a reality. ➦

*Carole Lambert is Vice President, Practice Optimization for CAP. Questions or comments related to this article may be sent to [clambert@CAPphysicians.com](mailto:clambert@CAPphysicians.com).*

# Risk Management and Patient Safety News



## Aging Population: Tools and Tips for Successful Engagement

by Ann Whitehead, RN, JD

In a report from the Centers for Disease Control and Prevention (CDC), one in five Americans will be a senior citizen by 2030, nearly double the 12 percent in 2000. Not only are there more seniors, but they are also living longer and experiencing multiple chronic conditions.

By 2050, the U.S. population of those aged 65 years and older is expected to comprise 20 percent of the population, of which approximately 19 million will be people aged 85 years or older. Of these older Americans, it is estimated that 30 percent will require care for their multiple comorbidities.

As the population of older Americans expands and baby boomers turn 65, a growing number of older Americans expect to live healthy lives well into their seventies, eighties, and nineties. This growing number of older adults, and the families who care for them, will need emotional, educational, and financial resources that are not currently available.

The simple, most expeditious way to identify the needs of your aging patient population is to engage the patient and family in their care in both the ambulatory and inpatient settings and assess their individual needs. Whom do they live with? Do they understand their medications? What language barriers do they experience? Do they have a family support base? Have they been hospitalized recently as a result of noncompliance with medications or medical treatment advice?

Asking these simple questions may reveal clues to perceived issues of compliance, disengagement, or misunderstanding and communication errors. The best way to deal with these areas of concern, in the ambulatory setting, is to encourage patient preparation and engagement for each appointment. The Agency for Healthcare Research and Quality (AHRQ) provides some tools to assist patients and their families become more fully engaged in their medical appointments. The tools encourage patients to prepare for their appointment, to speak up and ask questions, and to take notes.

Aging patients quite frequently are confused or unsure about their medications, especially when new medications are added

or after changes due to hospitalization. Many medical malpractice lawsuits include allegations of medication errors or lack of informed consent, alleging errors due to lack of communication. Therefore, an accurate medication list, fully discussed, is an important tool to prevent medication errors. AHRQ provides a sample medication list and a patient reminder tool to engage patients and caregivers to create a complete and accurate medication list using the brown bag method. Additionally, patient and family engagement is also a priority at the time of hospital discharge. Hospitalists are encouraged to:

- Provide the patient and/or family with clear and specific discharge instructions.
- Furnish a complete and correct list of medications, administration instructions, and side effects.
- Instruct the patient on scheduling a follow-up appointment with their PCP.
- Provide information about which provider to contact for questions, concerns, or problems.
- Transmit a comprehensive written discharge summary to the outpatient healthcare provider.

Ambulatory care providers also should establish discharge systems:

- Designate an office staff member to field calls from newly discharged patients.
- Create a system that notifies office staff when patients are discharged.
- Patients should never be discharged without adequate instruction and education.
- Actively perform a medication reconciliation at the first visit.

We are in the midst of an important and potentially transformative shift related to patients' roles in healthcare. Active patient and family engagement in their health and will strengthen decision making, improve health, reduce liability, and is key to error and injury prevention. ➦

*Ann Whitehead is Vice President Risk Management and Patient Safety for CAP. Questions or comments related to this article should be directed to [awhitehead@CAPphysicians.com](mailto:awhitehead@CAPphysicians.com).*

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# Case of the Month

by Gordon Ownby



## When the Specialist and the PCP Need to Have ‘The Talk’

It's a common scenario: A primary care physician refers his or her patient to a specialist for an acute condition. The specialist works up the patient and prescribes medication, for which the primary care physician is expected to issue refills. Who is responsible for monitoring the medication?

A middle-aged truck driver had been seeing Dr. PC for a number of years for sleep apnea, breathing problems, high cholesterol, and high blood pressure. Dr. PC had the patient undergo intermittent thyroid panels because of weight concerns, and the results over several years were within normal limits. But when the patient requested a thyroid panel at a visit three years on, Dr. PC noticed her patient was tachycardic. An EKG revealed atrial fibrillation, and the patient was wheeled to the hospital across the parking lot.

At the hospital, the patient's cardiologists diagnosed hypertrophic cardiomyopathy, and the gentleman was discharged four days later with prescriptions for Amiodarone 200 mg twice daily, as well as Coreg, Digoxin, Lasix, and Coumadin. The patient's thyroid stimulating hormone (TSH) test was within normal limits on discharge.

The patient saw his cardiologist, Dr. C, the next week and several times further that year. He also continued to see Dr. PC, who in fact sought Dr. C's clearance prior to the patient's surgery for a shoulder injury. Dr. C wrote to Dr. PC and thanked her for the referral, described the patient's cardiac condition, and declared him to be at low to medium risk for the surgery. Dr. C advised Dr. PC that the patient "should stop his Coumadin prior to the surgery and restart it when you feel he is safe post-operatively."

At a visit to Dr. C later that year, the patient said that he had gained weight, tired easily, and had difficulty breathing on exertion. His heart rate was 50 and his blood pressure was 90/58. Dr. C ordered an echocardiogram, chest X-ray, and CT angiogram. Dr. C decreased the patient's Amiodarone bedtime dose to one-half tablet.

The echocardiogram performed two weeks later suggested hypertrophic cardiomyopathy.

However, three weeks later (and prior to getting the CT), the patient was found unconscious by his neighbors. He received Amiodarone by the EMT and again at the ER.

Lab work at the hospital revealed TSH of 121.32 – an elevated value that was commented on by two consulting cardiologists and an endocrinologist. One cardiologist noted that hypothyroidism appeared to play a significant role in the patient's bradycardic disorder. The patient was discharged three weeks later for rehabilitation and sued Dr. PC and Dr. C for medical negligence. Neither had tested the patient's thyroid levels during his course on Amiodarone.

During the litigation, the plaintiff's attorney presented a declaration by an expert internist stating that as the patient's primary care physician, Dr. PC had a duty to know the potential side effects of her patient's medications. According to the declaration, Dr. PC had a duty to order a thyroid function test while the patient was on Amiodarone or to communicate with Dr. C on whether he had ordered a recent thyroid screening test. Another declaration, by a cardiologist, concluded that had either Dr. PC or Dr. C ordered a TSH screening test during their treatment of the patient, the patient's hypothyroidism would have been diagnosed and the cardiac event avoided. The litigation resolved informally prior to trial.

The risk management lesson here is not whether the cardiologist or the primary care physician had primary responsibility to monitor the medication. Rather, communication with each other as to who would take on that responsibility would have provided the win-win solution for all involved. ⚡

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