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CAPsules

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Country Doctor's Son Continues Tradition of Independent Care

Dr. Raleigh Unterseher works tirelessly to provide care that is personal, thoughtful, and delivers real value.

Some OB/GYNs deliver their first baby in a brightly lit, sterile operating room of a big city. Dr. Raleigh Unterseher delivered his to a proud mama cow in a barn in Milton-Freewater, Oregon.

"We had horses and cows, and from the time I was very young I got to assist on some interesting deliveries — including a c-section of a cow. My job was to hold the bowels out of the way. It was a success — the vet saved the cow and the calf," Dr. Unterseher recalls.

Growing up on a farm as the son of a country doctor was a unique experience. "My dad would take me with him when he did home calls. I was fascinated by his classic black doctor's bag, the secrets of healing, and the magic inside."

But it was not a straight line from there to the successful OB/GYN practice he runs today. "Early in college, I was a ski instructor, spent too much time in a Cessna 150 and Piper Cherokee Warrior trying to get enough hours for my pilot's license, and played far too many intramural sports."

But eventually, he buckled down, took his MCATs, and went to medical school. His experience made some of the material familiar. "But I was still a small town kid with a lot of formal studying to do to catch up to my peers."

"The best part of private practice is the intimacy and boutique feeling. We come to work every day and push to provide the best possible care. The responsibility is high… but so is the satisfaction."

After graduation, it was hard to choose a specialty, so Dr. Unterseher let the matching process decide. He was matched with an OB/GYN program at Glendale Adventist Hospital, and so he and his new wife Ronda (they got married the night before he graduated college) loaded a truck and drove to Glendale, California. "I really enjoyed all the faculty and residents. When they asked me to stay on as faculty, I enthusiastically said 'yes' and remained there for 10 years."

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DR. RALEIGH UNTERSEHER AT-A-GLANCE

Medical Specialty: Obstetrician and Gynecologist
Practice Location: Chico
Years in Practice: 27
CAP Member Since: 2008

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In 1999, he moved to Northern California to become the first specialist among a group of family practice doctors. But after two years, he decided to go solo. He admits it was a contrarian move, but 17 years later, Dr. Unterseher still knows he made the right decision.

Sure, he misses seeing the Dodgers and still treasures his 1988 World Series hat. But, "Chico is a lot like where I grew up. And with Chico State University here, there's a great combination of big-town amenities and small-town charm."

Dr. Unterseher joined CAP in 2008. "I'd had some painful experiences with another provider. But CAP has great values and strong capabilities. I joined CAP's Northern California District Council in 2010, and later signed up for its disability and life insurance products too."

When he is not at the office, Dr. Unterseher is passionate about water skiing. In Glendale, he led the OB/GYN Resident Water Ski Day every June. He was coached by world champion Marcus Brown. "I started water skiing when I was five at my family's summer cabin in Priest Lake, Idaho, and have only missed a few summers since," he says. His whole family water skis: his two daughters (one an occupational therapist, the other a dental hygienist), and his wife, who usually drives the boat.

He is also a trumpeter whose claim to fame includes winning the Pea Festival talent show. "My town, Milton-Freewater, used to be the pea capital of the world. We had an annual pea queen, a parade, and everything." Today, he and some physician colleagues play in a brass quintet. The lack of a permanent band name is a running joke. "We have been the Brass Kissers, the High Deductibles, and the Melodious Maladies."

But while he enjoys his hobbies, medicine remains his first passion. "The best part of private practice is the intimacy and boutique feeling. We come to work every day and push to provide the best possible care. The responsibility is high… but so is the satisfaction."

That is an old-fashioned attitude and one that his country doctor father would surely have approved.

CMS Regulatory Updates

The Fate of Healthcare Under the Trump Administration and the 115th Congress

by Miranda Franco, MA

Six years after the biggest overhaul of U.S. healthcare in half a century, the industry is bracing for more change under President-elect Donald Trump. There are a lot of policy questions and moving parts to follow. However, there is no question that the healthcare landscape will significantly change over the coming years.

Affordable Care Act

While Republicans have the majority in the Senate, they do not have a filibuster-proof majority. Thus, it's unlikely they will be able to repeal the ACA as it was enacted as doing so would require 60 votes. Rather, Republican leadership is expected to pursue partial repeal of the

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ACA through the budget reconciliation process, which allows for expedited consideration, without being subject to a filibuster. It is likely Congress will pursue partial repeal under reconciliation, but then phase-in over three years a replacement plan.

Medicaid

Various plans have been floated over the years to reform the Medicaid system. The most popular amongst Congressional Republicans are plans to provide states with more flexibility in managing the Medicaid system in their states through block granting or per capita allotment. These changes would likely require legislative action. However, the incoming Administration is expected to offer states greater flexibility through the waiver process that is currently in place.

Medicare

Both Speaker Paul Ryan and HHS Secretary Nominee Tom Price support converting Medicare to a premium support model. Price told reporters earlier this month that he expects Congress to push for Medicare changes during the FY 2018 budget reconciliation process in the third quarter of 2017. However, many are skeptical there are 51 votes for that change in the Senate, as Senate Democrats are sure to stand firm against Republican-led efforts, and moderate Republicans have been skeptical of these plans in the past. Additionally, President-elect Trump has not shown any interest in dramatic changes to the Medicare program.

Impact on Physicians

Providers will want to ensure that any potential ACA replacement does not reduce insurance coverage for their patients or impede access to their services and does not result in dramatically reduced reimbursement from all payers. Consideration of major repeal or changes to ACA is both a potential threat and opportunity for providers.

President-elect Trump and other Republicans have proposed significant Medicaid reforms by limiting the growth of federal funding for Medicaid while shifting greater control over eligibility and benefits to states. Such reforms—whether in the form of per capita allotments or block grants—might lead states to alter some combination of eligibility, benefits, and payment rates.

Greater flexibility could also spur innovation and structural changes on a state-by-state basis. For providers, such major changes may impact revenue, volume, and service offerings. There is no proposed replacement for the continuation of value-based payment models for a variety of providers subject to them under which they are rewarded or penalized in their Medicare reimbursements based on actual performance on a wide range of quality and outcome metrics—such as ACOs and bundled payments. Should efforts be advanced to temper value-based payment models, there may be an impact on the implementation of the Medicare Access and CHIP Reauthorization Act (MACRA).

However, many providers and other stakeholders might well voice a preference for value-based models as a cost control strategy over fee-for-service rate cuts. That viewpoint could encourage the new Congress and Administration to continue to support risk-based payment and pay-for-performance models.

Some proposals coming from Republicans, including medical liability reform and repeal of the Independent Payment Advisory Board (IPAB), will be welcomed by the provider community.

Miranda Franco is senior public affairs adviser for Holland & Knight LLP. Questions or comments related to this article should be directed to Miranda.Franco@hklaw.com.

Risk Management and Patient Safety News

Patient Expectations: The Root of All Evil?

by Lee McMullin, CPHRM

We have all heard the colloquialism, "Don't count your chickens until they've hatched," yet in healthcare we tend to frequently do so, especially in the immediate post-op period.

Take, for example, the post-surgical discussion with the patient and family that surgery went as planned. Sometimes we even dare say there were "no complications." Then, seemingly out of the darkness, comes a "complication" that sets the patient back a month or more and hits like an ambush out of a bad Western. And therein lies the root of this article – a complication should never take a patient by surprise. While it may be disappointing, patients must not feel like their health has been ambushed. The cause rests with us in our lack of adequate assessment and management of patient expectations that can end up being our litigation storyline.

Many complications take time to evolve, and we can do a better job at educating patients about those. By assuring our patients understand and know what to recognize, we draw them closer into a healthcare partnership with us, so if or when a problem arises, it is not "what is wrong" but instead "I am having that complication we discussed."

Picking a body part to demonstrate this effect, let us talk about ureters and female abdominal surgeries. The effects of radiant energy from cautery may not be evident at the time you're looking for a problem, but arrives as a urinary issue days or weeks later. This is after the patient was told she had no surgical complications (you *do* put in the Op report that you inspected those little tubes along with bladder, bowel, and other parts all looking okay, right?)

The wiser alternative is to teach your patient that some complications are immediately obvious while others could arrive days or weeks later. That stages you to reiterate those at discharge, and primes the patient to know and look for symptoms to alert you. In turn, that can reduce the time between onset, diagnosis, and treatment. While the patient's experience may be disappointing, it is not shock and horror with your name attached – especially if you told them everything was "okay" when it really was not. The key is to manage the patient's expectations in advance and let adequate time pass so you in fact know you are truly beyond the reach of those insidious and not immediately apparent problems.

That brings us full circle to the concept that "good consent" is expectation management. It is a harmonious compilation of your expectation assessment and your oral discussion on the risks and benefits of your proposed procedure. As to the consent form, it is just that – a "form." It does not itself prove you discussed anything with your patient. It only proves the patient signed a form. Without documenting your discussion in the record to marry the form into the consent process, the marriage is incomplete. Always take a few extra minutes to go over what the patient expects and jot down a comment that you discussed the risks and benefits…and don't forget those insidiously sneaky complications in the process.

Lee McMullin is a senior risk management and patient safety specialist in the CAP Cares service area. Questions or comments related to this article should be directed to lmcmullin@CAPphysicians.com.

Case of the Month

by Gordon Ownby

Court Backs Physician's Voluntary DMV Report on Patient

Rejecting a challenge over confidentiality, the Court of Appeal says California law supports a physician who struggled with her decision to report her patient's condition to the Department of Motor Vehicles.

In 2002, Michael McNair, a commercial driver for two years, reported during a neuropsychiatric evaluation that he followed his own bus routes, didn't like to babysit people, and on one occasion drove a group of children from San Diego to Tijuana by mistake because he "just didn't think."

In 2004, Mr. McNair asked Ann Kim, MD, an internist employed by the San Francisco Department of Public Health, to determine his eligibility for renewal of his commercial driver's license. Dr. Kim refused to so certify Mr. McNair based on his cognitive disorder and uncontrolled diabetes. In 2005, Dr. Kim wrote a letter in support of Mr. McNair's application for Social Security Insurance disability benefits by stating her opinion that he was not able to hold down any kind of full-time job.

The next year, however, Mr. McNair told Dr. Kim that he had been hired as a bus driver. She told him that he should not be driving children because of his poor health and that she was inclined to write to the DMV about his medical condition. Though Mr. McNair stated that he did not want Dr. Kim to communicate to the DMV, the internist wrote a letter concerning Mr. McNair's diagnosis of Cognitive Disorder NOS.

In that letter, Dr. Kim referred to Mr. McNair's 2002 neuropsychiatric evaluator's comment advising against renewal of his professional driving license and described a follow-up evaluator's report in 2005 as saying Mr. McNair "lacks capacity to set limits on himself and fails to understand the consequences of his behavior."

When the DMV subsequently revoked his commercial license, Mr. McNair sued the City and County of San Francisco and Dr. Kim for intentionally violating California's medical privacy laws. The trial court dismissed the claim after ruling that Dr. Kim's communication fell within California's "litigation privilege."

On review, the Fourth District Court of Appeal in *McNair v. City and County of San Francisco* said that Dr. Kim wrote her letter "out of concern for McNair's safety and the safety of the public" and that she based her letter on her own observations and on the reports of other specialists. The Court of Appeal noted that Dr. Kim did not immediately contact the DMV after learning of Mr. McNair's new employment "because she was wrestling with the decision whether to protect her patient's confidentiality or to disclose McNair's information for the safety of the public." Once Dr. Kim learned that her patient would be driving a school bus, that "just kind of pushed the balance."

Prior to sending her letter, Dr. Kim had reviewed the DMV's website, which stated: *Physicians are required by law (Health & Safety Code Section 103900) to report disorders characterized by lapses of consciousness, as well as Alzheimer's disease and related disorders. Additionally, they may report any other condition if they believe it would affect the driver's ability to drive safely.*

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In upholding the lower court's dismissal, the Court of Appeal noted that California's litigation privilege applied to Dr. Kim's letter as it involved a "quasi-judicial proceeding" (i.e., the DMV's review of drivers' qualifications to drive safely) and was made by an "authorized" individual (Dr. Kim, as a licensed physician), among other considerations. With regard to whether Dr. Kim violated California's medical privacy laws, the court said that the confidentiality statute itself, Civil Code 56.10, contains provisions in which disclosure of confidential information is either mandatory or permissive.

"Because California has a policy of encouraging reports regarding suspected unsafe drivers, [the state's medical confidentiality laws] must be construed in a way that will not impede voluntary reports of the type generated by Dr. Kim. . . ."

Gordon Ownby is general counsel for CAP. Questions or comments related to this article should be directed to gownby@CAPphysicians.com.

New Law Restricts Who May Be Excluded From Workers' Compensation Coverage

Making It Harder for Partners to Escape the Workers' Compensation System

The California Legislature recently passed AB 2883, which will take effect January 1, 2017 and affects all workers' compensation insurance business, including all currently in-force policies. The new law clarifies who may be excluded from coverage and the method by which an individual may be excluded.

Corporations, Partnerships, and LLCs

Prior to the passage of AB 2883, officers, directors, and working partners were not required to be covered under a business' workers' compensation policy unless they elected to be covered.

AB 2883 revised the exemption language to permit only officers and directors that own at least 15 percent of the corporation's stock, or who are a general partner of a partnership or a managing member of a limited liability company, to be exempt. The new law now requires everyone in such organizations to be covered under workers' compensation insurance unless they meet the new eligibility requirements and sign a waiver under penalty of perjury stating they do qualify for exempt status.

A separate, signed waiver is required for each individual electing to be excluded from coverage and is not effective until received and accepted by the workers' compensation insurance carrier.

This means you may be hearing from your workers' compensation insurance carrier to determine if the officers you excluded on your policy do qualify. Also, everyone who does qualify must sign the waiver required by law, even if they already have an exempt status on the policy. Otherwise, individuals currently excluded from coverage will be added to the workers' compensation policy, which may result in additional premium owed at the time of premium audit.

CAP Agency is here to help and support you through this new change. Please feel free to contact us by phone at 800-819-0061 or email CAPAgency@CAPphysicians.com with your questions.

Federal Cures Act: Into the Final Stretch

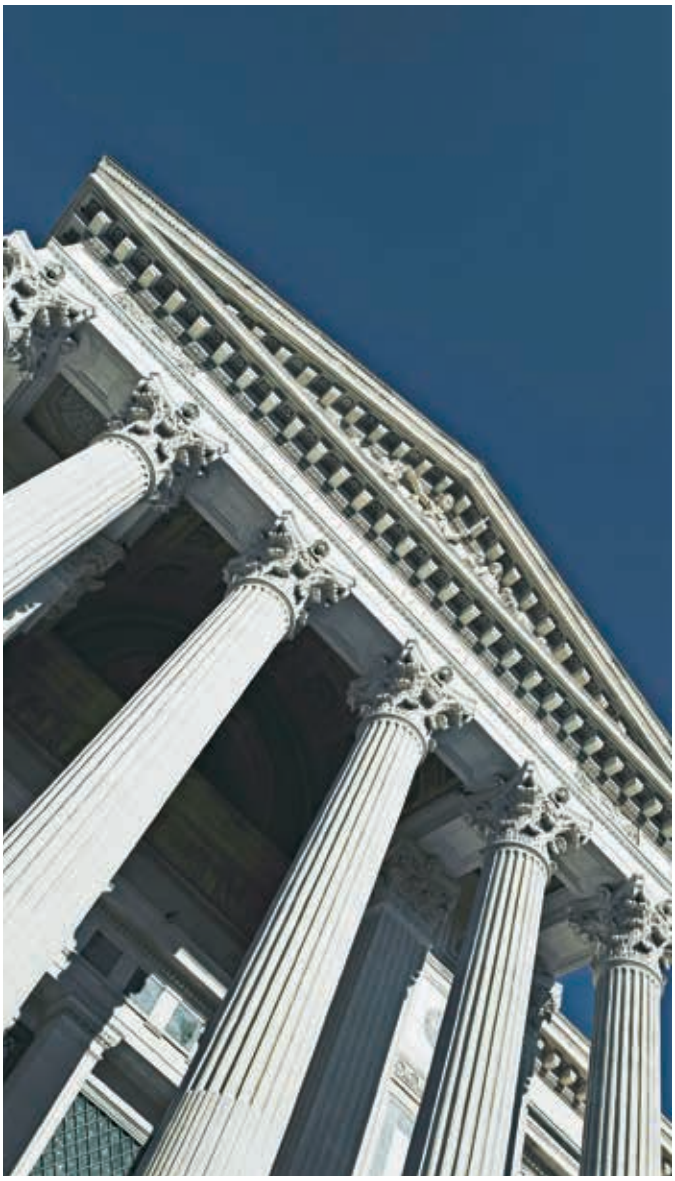
The lame duck session in Congress has seen very little legislative activity save for the 21st Century Cures Act (H.R. 6), which has passed both the House and Senate in a rare bipartisan accomplishment.

Marked as a priority for the Republican leadership seeking to pass the bill during the remaining weeks of the post-election session, a compromise version was released over the Thanksgiving holiday weekend. Through its three-year journey of hearings, debates, and lobbying from multiple stakeholders, the latest version was voted on and passed out of the House on November 30 by a vote of 392 to 26 and a Senate vote of 94 to 5 came in a week later on December 7. President Obama has praised these efforts and said he would sign it.

Introduced to Congress and championed by Rep. Fred Upton (R-MI), the bill has been lauded as the "Innovation Bill" because of its $4.8 billion designated for three signature Obama administration research programs over the next 10 years: Vice President Joe Biden's "Cancer Moonshot," the BRAIN Initiative, and the Precision Medicine Initiative. In addition, H.R. 6 also gives states $1 billion to fight the nation's opioid crisis. Disappointing to some Democrats, however, is that only $500 million will go to the Food and Drug Administration. A provision of the bill will require that the flow of money be reauthorized each year.

At 996 pages, the bill generated very heavy lobbying efforts from multiple stakeholders — from trade groups to academia, hospitals, medical schools, and medical associations. Some continue to strongly express concerns over the easing of FDA approval standards for new drugs and medical devices, while others applaud it and see the FDA changes as an opportunity to create an accelerated approval pathway.

The Cures Act also eases a provision in the Affordable Care Act called the Physician Payment Sunshine Act. The Sunshine Act requires drug and device companies



to publicly report virtually all payments to physicians, including meals, gifts, travel, and royalties, as well as speaking and consulting fees. As dozens of medical societies called for exemptions, under the Cures Act, companies will not have to report the value of textbooks and medical journal reprints given to doctors, nor will doctors need to disclose payments for continuing medical education courses.

President Obama will have up until his last day in office to sign the 21st Century Cures Act into law.

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