



COOPERATIVE OF
AMERICAN PHYSICIANS

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*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.*



CAP Discontinues Physician-Patient Arbitration Program

For many years, the Cooperative of American Physicians has supported arbitration as an alternative means for resolving disputes brought by patients over medical care.

The benefits to individual members of having such disputes decided in arbitration have included predictable arbitration schedules, private proceedings, and experienced professionals as the fact-finders. Another benefit shared by the membership as a whole has been cost savings in arbitration over the life of a litigated claim. The transformation of arbitration into a complex industry of its own, however, appears to have changed the dynamics with regard to its effectiveness.

CAP has previously shared with members our observation that while the result of any particular case will always depend on the medical facts, juries have awarded defense verdicts at a higher percentage rate than have arbitrators. Contrary to the early days of arbitration, we now customarily see trial dates scheduled earlier in the life of claims proceeding in the court system compared to their arbitration counterparts. More recently, CAP has also noticed that savings in overall costs of arbitration versus the court system can no longer be counted on.

The erosion in the benefits of arbitration coincides with what CAP perceives as improvements in the superior court system. The advent of "one-day or one-trial" jury-service rules and the limitations on jury-service excuses appear to have helped produce juror pools of citizens who are well capable of making difficult but just decisions.

With physician-patient arbitration no longer presenting clear-cut advantages to the membership, CAP will no



longer support arbitration as an alternative to the court system and will no longer supply arbitration agreement forms to CAP physicians and their medical practices. CAP recommends that members no longer offer arbitration agreements to new patients.

As for future claims brought against members by patients who have signed arbitration agreements, these members should discuss with their defense attorneys and claims services representatives whether to assert arbitration when a superior court lawsuit has been filed. (If an agreement between a physician and patient has been signed, the patient or family retains the right to pursue arbitration.) Any member wishing to explore terminating existing arbitration agreements with patients or having other questions about discontinuing arbitration should contact 213-576-8558.

Whether a claim is defended in superior court or in arbitration, CAP physicians can rely on their professional and experienced claims services representatives and defense attorneys to vigorously pursue the best result. The CAP Board of Directors and the Mutual Protection Trust Board of Trustees want you to know that this commitment to you remains beyond dispute. ➦

Introducing CAP's New Patient Experience Survey Program

Improving the Performance of Your Practice

CAP wants to help you take control of your patient satisfaction data. A new high-performance, online Patient Experience Survey Program (PESP) can help you attain a clear picture of what you are doing well, where you can improve, and how you stack up against other providers and practices.

As the reimbursement model shifts from fee-for-service to value-based compensation (VBC) and patient experience scores factor into reimbursement, it is paramount that physicians own their own data.

We are hosting a series of free, no-obligation, online demos in January and February from 12:30 p.m. to 1:00 p.m., so you can experience for yourself the value of this specialty-specific survey tool. Once you view the demo, you can immediately sign up for the program.

Thursday, January 14

Thursday, January 21

Thursday, February 11

Thursday February 25

"From the start, my experience with SE Healthcare's patient experience survey has been very positive. Implementation was simple, and I didn't have to jump through any hoops to get the program off the ground. There's nothing onerous about it, and I always receive my reports in my inbox on the 10th of every month, as promised. I highly recommend this survey to any practice looking for an affordable and effective way to report patient satisfaction."

- Pat Wilber, Chief Operating Officer
Genesis Healthcare Partners, San Diego

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Easily register for any of these demos by visiting www.CAPphysicians.com/pespdemo or by contacting Laura Tejero at 213-473-8638 or ltejero@CAPphysicians.com. Just let Laura know the date you would like to attend.

This HIPAA-compliant, easy-to-implement survey is now available to CAP members through an internationally recognized professional service firm, SE Healthcare Quality Consulting.

We hope you take time to participate in one of the brief demos. Once you view the demo, you can register directly online for this valuable survey tool, which is available at a low monthly fee per CAP provider. Should you have questions about PESP, please contact Laura Tejero at 213-473-8638 or ltejero@CAPphysicians.com. ➦

A Special Invitation to The Institute for Medical Leadership's Chief of Staff Boot Camp®



The Cooperative of American Physicians, Inc. is pleased to offer its members a \$100 discount for the Chief of Staff Boot Camp®, taking place January 22-23, 2016, in Santa Monica and February 26-27, 2016, in New Orleans. This means that for any CAP member or CAPAssurance hospital that would like to attend either Boot Camp, the tuition for physicians is \$995 (\$100 off the Early Bird tuition rate). Hospital CEOs or CMOs may attend for free if they bring two paying physicians.

CAP is cosponsoring these two upcoming events with The Institute for Medical Leadership® to help prepare hospital Chiefs of Staff, members of the Medical

Executive Committee, and other physician leaders for the challenges they face in the rapidly changing healthcare marketplace.

The intense two-day program will be led by esteemed industry professionals. The program also provides up to 14.5 AMA PRA Category 1 credits through CAP.

To secure your space at this special rate, contact the Chief of Staff Boot Camp® Program Director, Dr. Susan Reynolds, at sreynolds@medleadership.com or 800-361-5321. Use the code CMS to get the discount whether you call in or register online. For more information about the program, visit www.medleadership.com.

If you are unable to personally attend, please pass this offer to one of your colleagues who is currently a physician leader in your hospital or medical practice.

We hope you or a referred colleague will take advantage of this special offer. ➦

A Bill's Failed Past May Just Be a Prologue

Legislative bills die in Sacramento for a number of reasons, but a bill's failure does not mean an end to the ideas behind it.

While much gets reported on the bills the governor signs into law, there are hundreds more that receive no mention simply because they never make it to his desk. It is a tortuous process and much can happen along the way. Many times bills lose steam and die at some stage during the committee hearing process. Those that make it out of committees and on to their respective floors for a vote may encounter their demise in front of the entire body. Some make it out of the Legislature only to suffer a veto by the Governor. But even then, that is not always the end.

Depending on the circumstances, the ideas behind these rejected bills may see the light of committee rooms and analyst desks once more. One healthcare-related bill vetoed in the last legislative session could still make a phoenix proud.

Assembly Bill 159 was introduced by Assemblyman Ian Calderon (D-Montebello) and got the moniker of the "Right to Try" bill. AB 159 aimed to create a faster pathway to authorize a pharmaceutical manufacturer to make an investigational drug, biological product, or device available to eligible patients under specific circumstances. Through the process, the author accepted a number of amendments to

ensure proper protections for patients and their physicians. This type of legislation also has been introduced in a number of other states.

In a display of strong bipartisanship support, AB 159 cleared the Senate with a 40-0 vote and the Assembly 74-2. Governor Jerry Brown's



veto message, however, questioned the need for state legislation in a field regulated by the federal Food and Drug Administration. Authors of bills with that kind of support, however, often bring their ideas back in new legislation that attempts to address a governor's concerns.

Legislators return to their desks on Monday, January 4. ➦

Case of the Month

by Gordon Ownby



Post-Surgical Handoffs Invite Scrutiny

Patient coverage by trusted colleagues is a necessary part of practicing medicine. But post-surgical handoffs can become a focal point if things go wrong.

A 51-year-old woman visited Dr. OBG, an obstetrician-gynecologist, and told the physician that her menses had become heavier since being diagnosed with thrombocytopenia. Her surgical history included an ectopic pregnancy removal and an ovarian cystectomy. Dr. OBG's assessment included menopausal syndrome, ovarian cyst, and peri-menopausal menorrhagia. Dr. OBG ordered additional tests, including an ultrasound that showed a large benign-appearing cyst that appeared to have grown from that shown in an ultrasound five months earlier.

When the patient's complaints persisted over successive visits, Dr. OBG sought clearance for an exploratory laparotomy and left salpingo-oophorectomy. The woman's PCP cleared her for surgery, as did her hematologist – so long as the patient's platelets were above 75,000 and that she take 30 mg of prednisone daily before surgery. The patient consented to a laparoscopic procedure with possible exploratory laparotomy after acknowledging risks and alternatives.

Dr. OBG began the surgery laparoscopically with a 5mm incision, followed by placement of a 5mm trocar into the abdomen. After finding extensive adhesions, Dr. OBG changed the trocar position to the supra-umbilical area. When the adhesions persisted, Dr. OBG converted to an open procedure. Dr. OBG removed the cyst, left tube, and ovary and cauterized the bleeding areas of the uterus before closing.

The patient was seen the next day by another OBG in the medical group, who noted stable vital signs, diet tolerance, non-distended abdomen, and ability to walk about. When Dr. OBG saw the patient two days post-op, the patient reported nausea and moderate right-side gas pain. The patient's heart rate was 120. A V/Q scan came back

normal. Later that evening, the patient's temperature reached 100.8 degrees and Dr. OBG ordered Tylenol. A stat urinalysis was negative. Dr. OBG had a nurse contact a radiology technician regarding the patient's iodine allergy and a possible CT scan pending CBC results. The tech told the nurse preparation would take 13 hours prior to any CT scan. The next morning (post-op day three), the CBC results showed a normal WBC count of 7.9 with high bands of 54. Hemoglobin was low at 8.7 and the HCT was 25. Dr. OBG transferred the patient to telemetry with an order for two units of packed red blood cells transfused as soon as possible. When she saw the patient mid-morning, the woman complained of shortness of breath and increased "stiffness" and "tightening" of her abdomen.

Another one of Dr. OBG's partners assumed the care of the patient later that afternoon. The record shows the patient's iodine allergy continued to be a factor in the scheduling of a CT scan and at one point, the partner cancelled Dr. OBG's order for a scan.

When a stat CT with contrast was performed mid-morning on post-op day four, the study showed free air and fluid, a deep pelvic abscess, and a possible developing abscess on the abdominal wall. An exploratory laparotomy a few hours later found a perforated transverse colon and infection, necrosis, and fecal contamination. After debridement and anastomosis, the patient continued to have a complicated course and died several weeks later.

A claim brought by the patient's family was resolved informally.

Because every adverse event looks different through the proverbial "retrospectroscope," a clear record of communications between physicians in a handoff is essential in defending the critical decisions made in a patient's care. ➦

Gordon Ownby is CAP's General Counsel. Comments on Case of the Month may be directed to gownby@CAPphysicians.com.

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Tips for Talking to Patients About Meds

From hospital to home, studies confirm if it is going to go wrong, it will likely involve medications. Medication-related events account for up to two-thirds of post-discharge adverse events and are a major driver of hospital readmissions.

While meticulous medication reconciliation is essential to safe prescribing, obtaining a current and accurate medication list is a challenging and painstaking process.

- **Make It Meaningful:** When talking to patients and families, explain that obtaining an accurate medication list is critical to safe prescribing.
- **It is Only Natural:** While healthcare professionals are well aware of harmful interactions that occur when prescription medications interact with supplements, OTCs, and herbal preparations, patients may not volunteer this information. When interviewing, ask about prescription medications as well as over-the-counter medications, supplements, vitamins, herbal preparations, and nutraceuticals.
- **Ask, and Then Ask Again:** When memory fails, experts recommend rephrasing the question to trigger recall.
 - Ask about *doctors* – Asking about a particular doctor may trigger patient recall: “What medications does your kidney doctor prescribe? What about your heart doctor?”
 - Ask about *diagnoses* – Reviewing a problem list can offer insight into medications: “Are you currently

taking any medication for your heart condition? For your arthritis?”

- Ask about *frequency* – Patients often forget to include medications with infrequent dosing: “Are there any medications you take daily, weekly, or monthly?”
- Ask about *route* – In addition to inquiring about oral medications, ask patients about patches, eye drops, ear drops, injectables, and topical medications: “Is there any medication you put on your skin?”
- Ask about *location* – A mental tour of the home may yield discoveries: “Do you have any medications in your kitchen, on your nightstand, in your bathroom, or in your refrigerator?”
- **Digging Deeper – Uncovering Nonadherence:**
As any seasoned practitioner can attest, just because it is on the list, does not mean the patient is taking his or her medication or taking it as he or she should. It is important to not only ask *if* the patient is taking the medication, but *how* he or she is taking it. One way to start this conversation is by asking if there are any medications that they have questions about or ones that are not working for them.

- **When Communicating with Patients, Keep It Simple!** Low health literacy is one of the major factors contributing to medication nonadherence. It is important to understand that *any patient's ability* to comprehend and retain information can be adversely impacted by stress, pain, medication side effects, or simply a lack of familiarity with content. Therefore, some educators believe the best strategy is to use simple, plain language whenever possible. Plain language is language that would likely be immediately comprehensible to the majority of patients (e.g., it's "your blood pressure pill" versus "your antihypertensive medication"). Finally, when educating, use the "teach back" method to verify the patients' understanding. The teach-back method involves asking your patients to repeat in their own words what they need to do when they leave your office.

Providing patients with a master list of their reconciled medications, instructing them to carry the list to every physician appointment, and to update it whenever medications are started, stopped, or changed can help improve the medication history conundrum. Annotating the list with lay language and explanations of medication purposes (e.g., warfarin = blood thinner) can help assist patients to recognize and recall their medications. ➦

Foster, A.J., Murff, H.J., Peterson, J.F. et al. (2003). The incidence and severity of adverse events affecting patients after discharge from the hospital. *Ann Intern Med*, 2003 Feb 4; 138(3): 161-7.

U.S. Department of Health and Human Services, Office of Disease Prevention and Health Promotion. National Action Plan for Adverse Drug Event Prevention. Washington, DC: 2014: 5. Adapted from Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication.

Reconciliation. 2012; AHRQ Publication No. 11(12)-0059: 43.

