THE MONTHLY PUBLICATION FOR CAP MEMBERS

CAPsules

COOPERATIVE OF AMERICAN PHYSICIANS

CAP Celebrates 40 Years of Serving California's Healthcare Providers

This year, CAP celebrates 40 years of being at the forefront of providing superior medical professional liability protection through its flagship product, the Mutual Protection Trust (MPT). Since 1977, MPT has proudly offered considerable peace of mind to California healthcare providers. The product continues to deliver robust coverage solutions in today's dynamic and fast-changing environment.

CELEBRATING
40
YEARS OF SUPERIOR PROTECTION

As a strong alternative to traditional insurance for solo and small group practices, MPT has over the past four decades earned a reputation for providing first-class coverage at a highly affordable rate. Leveraging disciplined underwriting, proactive risk management, and expert claims representation, CAP is able to deliver a market-leading product with numerous value-added services. These include a 24-hour adverse outcomes hotline, human resources support, electronic health record (EHR) consultation, and more.

"In 2016, CAP's MPT earned an A+ (Superior) financial rating from A.M. Best for the eleventh consecutive year," said MPT Board of Trustees Chair Charles P. Steinmann, MD. "This is a testament to the financial vigor and stability of our offerings, as well as the high standards to which we adhere as an organization."

In addition to medical malpractice coverage, CAP offers members an extensive line of high-quality business and personal insurance products through its wholly owned subsidiary, CAP Physicians Insurance Agency (CAP Agency). CAP Agency not only administers the value-added insurance and other benefits members automatically receive when they join CAP, but also provides them with the opportunity to purchase competitively priced insurance products from top-rated carriers.

In 2013, CAP introduced CAPAssurance, a Risk Purchasing Group, to bring liability insurance coverage to hospitals, healthcare facilities, and large medical groups. This offers professional liability solutions that recognize and respond to the unique financial and operational challenges often associated with larger entities.

"In today's rapidly evolving healthcare environment, CAP's value proposition is more pronounced than ever," said CAP and MPT Chief Executive Officer Sarah Pacini. "With considerable experience in delivering outstanding coverage and counsel, as well as an unwavering commitment to continuing education, we are well-positioned to help our members nimbly adapt and navigate the challenges presented by nascent regulatory requirements and market forces."

CAP President and Board of Directors Chair Béla S. Kenessey, MD, emphasizes, "As a practicing physician myself, I can attest to the immeasurable return on investment that CAP provides its members – especially during this transformational period in the healthcare sector. CAP's staff harbors exceptional acumen across the strata of legal, regulatory, risk management, claims, human resources, patient engagement, and more. They remain constantly apprised of the latest industry developments to ensure that CAP's offerings are timely, relevant, and highly beneficial. Their support allows physicians to focus on what matters most – providing optimal care to patients."

March 2017

Medicaid Funding: Exploring Per Capita Allotments

Public Policy

March 2017

Last month, *CAPsules* addressed alternatives to current methods for federal funding of Medicaid and examined "block grants" -- a method by which a total fixed dollar amount is given to every state to run the program. Another path being considered is the "per capita allotment" model, consisting of a per-patient-per-month capped amount.

The restructuring of Medicaid funding forms part of the current debate over proposed methods to repeal the Affordable Care Act (ACA). House Speaker Paul Ryan (R-WI) made this an integral piece in his plan, "A Better Way: Our Vision for a Confident America," produced by the GOP Health Care Reform Task Force. Among the many healthcare related topics in it, more details are laid out as to how this per capita allotment model would be structured, including statutory changes to grant states greater flexibility to determine eligibility and level of benefits.

At the center of both models is the assertion that reform will mean greater empowerment for states to run their Medicaid programs ("Medi-Cal" in California). But the proposals differ greatly, in that block grants do not account for growing enrollment while the per-capita caps model does. Considering that Medicaid is today's largest single insurer (providing coverage and care for over 73 million low-income individuals -- and growing), the per capita allotment approach would account for all persons enrolled in the program and also those who might not have been expected to sign.

In its most basic form, a per capita allotment would be the product of caps designated for the four major beneficiary categories—aged, blind and disabled, children, and adults—and the number of enrollees in each of those four categories. Excluded from the allotment and calculated through a separate funding stream would be federal payments to states with Disproportionate Share Hospital programs, as these hospital facilities qualify for adjustments due to the significantly greater number of low-income and/or uninsured patients they serve.

Should this model be adopted, allotments would be applied in 2019 with amounts determined by each state's average medical assistance and non-benefit expenditures per full-year during base year 2016. While the report recognizes that Medicaid is a "critical lifeline for some of our nation's most vulnerable patients," the "A Better Way" plan proposes models that ultimately result in substantially scaling back federal monetary contributions to these programs.

What would block grants or limits on per capita spending mean for Medicaid? Visit http://www.commonwealthfund.org/publications/issue-briefs/2016/nov/medicaid-block-grants.
See also "A Better Way: Our Vision for a Confident America," www.better.gop.

The Successful Physician

by Carole A. Lambert, MPA, RN

The Patient Experience – A Cornerstone of Care

In 2015, CAP partnered with SE Consulting to provide CAP member physicians and their staff with the Patient Experience Survey Program. The program is an important part of our strategic response to the present and our plans for the future.

CAP member physicians and their staff expend tremendous effort to create an environment of courtesy, calm, efficiency, and effectiveness to share with patients and their families. This is what we believe we are doing, but can we know how we are doing? Can we capture the voice of the patient and his or her family? Can we validate our belief and confirm that we are becoming the place and provider of choice?

In a recent webinar, "Learning From Patient Experience: Where We Have Been and Where We Can Go," Rachel Grob, PhD, noted, " The patient experience is no longer a 'nice to know' but a cornerstone of care." The Patient Experience Survey's clear and direct questions ask the patient about the courtesy, calmness, effectiveness, and efficiency we believe we provide. The patient's responses are the measure of our success, or a guide to where and how we can improve. How does the evolving healthcare landscape relate to concerns regarding reimbursement, quality, safety, value, and patient choice?

Demonstrating our worth and value through measurement reflects our confidence and our flexibility as organizations, small or large, that can learn and adapt. Evaluating our work is not a discussion of right versus wrong or good versus bad. It is a consideration of what is and how to deal with it. Measuring the experiences of patients and families gives us feedback that can act as a bellwether or, in some cases, a red flag.

Purchasing healthcare is unlike other buying decisions. Demand is unpredictable and can be urgent, coming from a person in need with his or her own emotional, cultural, and financial context, and affected by availability and perceived quality.

Patient and family expectations are continually evolving, changing, and increasing, placing corresponding demands on the physician and staff. Earl Naumann, PhD, in his white paper, "Creating Customer Value, the linkage between value, customer satisfaction, customer loyalty, and profitability," observes, "The rapidly changing, intensely competitive business environment of today demands that firms be proactive, innovative, and more customer-driven than ever before."

We encourage CAP members to take advantage of the user-friendly technology of the Patient Experience Survey Program to obtain timely, relevant, meaningful, and useful feedback that validates the efforts of CAP member physicians and their staff to create environments, systems, and experiences that attract and retain patients. To paraphrase Mark P. Herzog in "How Real is Healthcare Consumerism?", patients' responses to CAP's Patient Experience Survey will help member physicians' practices "sustain and preserve the best parts, but make the changes patients need from us."

Participating in the Patient Experience Survey Program is facilitated by Laurie Travisano at SE Consulting. For information and assistance with getting started, contact Laurie at lct@sehqc.com.

Carole Lambert is Vice President, Practice Optimization for CAP. Questions or comments related to this article may be sent to clambert@CAPphysicians.com.

Risk Management and Patient Safety News

Four Tactics to Stop Medication Errors in Your Office

by Amy McLain, BSN, RN

A recent focused review of CAP's closed-claims data by Risk Management and Patient Safety staff reveals that 62 percent of medication errors involving Medical Assistants (MA) occurred in busy primary care practices. These errors were directly associated with injectable medications, such as vaccines, antibiotics, numbing agents, and corticosteroids. Surprisingly, one particular medication made a frequent appearance – the glucocorticoid corticosteroid, Kenalog.

A notable case involved a 31-year-old female who was being treated for an insect bite and received a Kenalog injection in her right upper arm by an MA. The patient later complained of right arm weakness, as well as a palpable lump, a tingling sensation, and pain at the injection site. It was determined that the drug leaked out into the patient's surrounding adipose tissue, causing necrosis and dimpling. With proper training, the MA would have known to inject the drug employing a Z-track technique deep into the gluteal muscle using a needle at least 1.5 inches long, as indicated in the manufacturer's medication insert.

Additionally, the CAP Cares team frequently receives calls on the CAP Hotline from member offices wanting guidance in dealing with adverse patient outcomes due to the improper administration of Kenalog. Their unhappy patients sometimes require additional treatment, such as tissue expanders, or liposculpture and fat grafting performed by a surgeon and want the physician to pay for it. We are certain that many adverse outcomes involving Kenalog go unreported to CAP and not every call to the Hotline turns into a claim, but we do know that these errors are preventable and cost the patient, the physicians, and CAP a lot of time and money. The case mentioned earlier settled for $29,999 with just over $20,679 in expenses paid.

CAP Recommends:

- MAs should be trained in the administration of Kenalog and other injectable medications. Competency should be verified and documented by a qualified, licensed clinician, such as a physician, nurse practitioner, physician assistant, or nurse midwife.

- Before a Kenalog injection is given to a patient, a physician must discuss the medication with the patient, including its risks, benefits, side effects, and complications.

- Provide the patient with written patient education about Kenalog. Include a signature line on the handout for the patient and a witness to sign documenting informed consent. The original signed handout should be placed in the patient's chart and a copy should be given to the patient.

- All Kenalog injections should be given according to manufacturer's directions – deep into the gluteal muscle (buttocks). It should never be given in the deltoid (upper arm). A Z-track technique is recommended to prevent the medication from leaking into surrounding adipose tissue.

If your MA will be delegated the skillful task of giving injections, such as Kenalog, it is essential that our member physicians provide them with the training necessary to do so safely. Medication errors are preventable. Safe medication administration improves patient safety and reduces medical liability risk.

Amy McLain is a Senior Risk Management and Patient Safety Specialist for CAP. Questions or comments related to this article should be directed to amclain@CAPphysicians.com.

Case of the Month

by Gordon Ownby

Court Explains How to Analyze Time Limits in Failed Diagnosis Suits

The California Court of Appeal has offered a fresh explanation on how courts determine the legal date of an "injury" when the alleged medical error is a failure to diagnose.

Under California Code of Civil Procedure Section 340.5, a medical malpractice plaintiff must bring suit within three years of the date of injury or within one year after a plaintiff discovers the injury, whichever comes first. But what if a plaintiff suspects negligence before he knows the extent of his injury? That was the question posed in a new case, *Drexler v. Peterson*, which explains that in missed diagnosis cases, the legal definition of "injury" is critical. (As in many appellate cases, the court assumed the following allegations as true in order to articulate its view of the law. The ultimate facts themselves are still subject to a jury's finding.)

From late 2006 to early 2011, Steve Drexler consulted with his primary care physician, David J. Peterson, MD, about his headaches. Over nine visits and calls, Mr. Drexler complained of severe headaches that began at the back of the head. Dr. Peterson diagnosed tension headaches and prescribed pain medication, physical therapy, and acupuncture and referred him to a chiropractor. At one point, when Mr. Drexler asked for an MRI, Dr. Peterson explained that his pain "remain[ed] in the occipital and in the trapezius distribution of the shoulder" and that an MRI would not add to the diagnosis.

In 2010, Mr. Drexler consulted with a neurologist for headaches and "right arm tingling" that he said had begun four to five years earlier after a trauma. The neurologist diagnosed carpal tunnel syndrome and tension headaches. Mr. Drexler continued to see Dr. Peterson, who maintained his diagnosis of "tension-type headache."

In a later deposition, Mr. Drexler testified that though he trusted Dr. Peterson, he never believed that his headaches were caused by tension or stress. He said that after the first few visits, he did not believe that Dr. Peterson properly diagnosed his headaches. He also testified that he had thought that his neurologist's diagnosis of carpal tunnel syndrome was "a joke."

In early 2013, Mr. Drexler went to the hospital after experiencing headaches, double vision, unsteady gait, progressive hoarseness, and difficulty swallowing. An MRI revealed a large brain tumor impinging on the brain stem, the surgical removal of which resulted in significant injuries. Mr. Drexler sued Dr. Peterson and his neurologist in July 2013, claiming negligent failure to diagnose.

At the trial court level, the judge dismissed the case after ruling that Mr. Drexler's claims were barred under the one-year statute of limitations because he had a suspicion of wrongdoing by Dr. Peterson and the neurologist by January 2011 and March 2010,

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respectively. The judge also ruled that the three-year limit had run on the claim against the neurologist because, the judge reasoned, the injury by the neurologist occurred in March 2010 when he failed to diagnose the tumor.

However, on appeal, the justices noted that as used in the statute, "injury" means both a person's physical condition and its "negligent cause." So while Mr. Drexler had formed a suspicion of wrongdoing by his physicians (and even consulted with an attorney) by January 2011, the appellate court said that the one-year and three-year "limitations periods did not begin until Drexler discovered his injury – that is, became aware of additional, appreciable harm from his preexisting condition . . . ."

The Los Angeles-based appellate court said that when a claim is based on a failure to diagnose, the injury is not the mere undetected existence of the medical problem. "Rather, the injury is the development of the problem into a more serious condition which poses a greater danger to the patient or requires an extensive treatment."

Because the evidence submitted to the trial court before the dismissal was open to interpretation on whether Mr. Drexler timely discovered his "injury," the Court of Appeal reinstated the suit for a factual determination on that issue.

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

From left to right): Jillian Prado, Janet Hemphill, Deidri Hoppe, Armenuhi Fodulyan, Diana Leoncio, Robyn Hastings, Scarlett Briggs, Hayde Lafarga, Les Fujimoto.

The CAP Agency Team: Here to Support Your Business and Personal Insurance Needs

Members of the Cooperative of American Physicians are privileged to receive a benefit not available through any other medical professional liability provider – exclusive access to a dedicated insurance agency. This means you not only receive as part of membership – at no additional cost – life, group disability, and cyber risk protection (among other valued-added coverages), but also access to purchase superior business and personal insurance all through one convenient source.

Unlike typical insurance agencies with a more sales-oriented business model, CAP Agency is a wholly owned subsidiary of CAP, so it is committed to offering outstanding insurance products at only competitive rates and serving as trusted consultants to help you determine what business coverages you may need – or not need – based on your individual circumstances.

In fact, one of our members recently told us, "The reason I like CAP Agency so much is because I can call anytime and ask questions about any type of insurance coverage whether or not I have a policy through them."

Each and every CAP Agency staff member knows that their most important role is to help support and guide you through the complex world of insurance coverages outside of medical professional liability.

Contact us today at 800-819-0061, or at CAPAgency@CAPphysicians.com and let us help you with any insurance needs or questions you might have. You can be confident you will receive the same exceptional care and service you receive with your MPT malpractice coverage.

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