THE MONTHLY PUBLICATION FOR CAP MEMBERS

CAPsules®

COOPERATIVE OF AMERICAN PHYSICIANS
CELEBRATING 40 YEARS OF SUPERIOR PROTECTION

Upcoming Elections and Annual Meeting

May is here and it is almost time for the Cooperative of American Physicians, Inc., ballot and Mutual Protection Trust proxy. Members will start receiving their mailed ballot and proxy materials the week of May 29. As a member of a physician owned and governed organization, this process is your opportunity to make your voice count.

The ballot and proxy will be used at the Annual Meeting of CAP and MPT Members, which will be held on July 27 at 8:00 a.m. in CAP's headquarters office in Los Angeles.

On the CAP ballot, members may vote on the nominees for the CAP Board of Directors and on a proposed amendment to the CAP Bylaws. Via the MPT proxy, MPT members may indicate their approval of nominees for the MPT Board of Trustees and their vote on proposed amendments to the MPT Agreement.

To complete the process, a majority of all members must respond. Each vote is important, and members have the opportunity to vote online by logging in at www.CAPphysicians.com. You also may choose to return your two-page ballot and proxy by fax or mail. In order to make this process efficient, we need your votes as early as possible.

If we do not receive a majority of the members' responses, we incur additional costs to contact those who have not responded, and may require a second mailing. The more votes we receive, the fewer resources will be required for follow-up calls and emails. Please vote early and encourage your fellow members to do the same.

May 2017

Bay Area Members: Litigation Education Retreat Is Coming Your Way

May 2017

On Saturday, June 17, CAP will host its popular Litigation Education Retreat in Pleasanton. This retreat provides invaluable support and guidance to Northern California area members currently facing a medical malpractice lawsuit.

This daylong event, facilitated by a legal communications specialist, a medical doctor, and malpractice attorneys, is intended to help physicians best prepare for trial and cope with stress and anxiety that they may experience when hit with a claim.

We encourage members to bring their spouses, as they play a critical support role. This retreat is included as part of your membership in CAP, so there is no charge to you or your guest. Lunch and refreshments will be served.

For additional information or to RSVP, please contact Andrea Crum at 213-473-8725 or LERinfo@CAPphysicians.com. CAP, a CME-accredited provider, designates this educational activity for a maximum of six AMA PRA Category 1 Credit(s)™.

Federal Medical Liability Reform Moves Forward

MICRA

After an initial attempt to repeal the Affordable Care Act (ACA), negotiations and discussions on such legislation continue on Capitol Hill. At the same time, House Republicans have sponsored and successfully passed out of committee a medical liability reform bill, H.R. 1215, titled the "Protecting Access to Care Act (PACA)." The bill is sponsored by Rep. Steve Knight (R-IA).

The House Judiciary Committee approved H.R. 1215 on February 28 by a vote of 18-17. This bill is based on California's Medical Injury Compensation Reform Act (MICRA) and would limit noneconomic damages in medical professional liability lawsuits to $250,000, while allowing for unlimited economic damages. The bill in its present form would allow state lawmakers to reserve the right to set the cap higher or lower than $250,000 while protecting existing state liability reforms. There is also language limiting its jurisdiction to apply to lawsuits in which patient care is covered under a federal program, be it Medicare, Medicaid, or a federally subsidized insurance plan under the ACA. The bill also limits the size of the "award based fees" attorneys could collect. Under the formula in the bill, the lawyers could collect up to 40 percent of the first $50,000 in recoveries, but only 15 percent of any amount recovered over $600,000.

House Republican leadership considers this measure to be part of its overall healthcare reform efforts with the support of a Congressional Budget Office estimate that the bill would reduce federal budget deficits by almost $50 billion over 10 years.

With the bill out of the House Judiciary Committee and discharged out of the House Energy & Commerce Committee, it is eligible for full debate on the House floor. That floor debate has been delayed, however, apparently over ACA repeal and replace negotiations.

The Successful Physician

by Carole A. Lambert, MPA, RN

Performance Improvement, Short and Sweet: Take Credit for What You Do Best

What steps have you taken in your practice to increase access and improve quality, contain costs, and create a positive environment for your patients, your staff, and you? Having taken those steps, not only are you working toward achieving the Quadruple Aim, you also are participating in the new category, Improvement Activities (IA), of the Merit-based Incentive Payment System, or MIPS.

While we have always managed metrics, the continuing evolution of payment reform as evidenced by the Quality Payment Program (QPP) has, at times, felt like a rockslide bearing down on us. Our responses take a variety of forms: eyerolling, hand-wringing, expletives, refusal to participate, or maybe — just maybe — the realization that we have been monitoring, evaluating, and modifying our systems and practices all along. Briefly, your IA score is weighted 15 percent of your total MIPS score; and an IA score of 40 points equals 100 percent credit.

The IA category of MIPS, despite the wordiness of its title, gives us an opportunity to identify, clarify, and account for the things we do best. The nine subcategories and the approximately 90 activities distributed among those subcategories allow us to document our meaningful interactions and interventions for the health and well-being of our patients and their families. High-weighted activities are worth 20 points, and medium-weighted activities are worth 10 points.

Let's focus on just a few of the activities listed – high-weighted activities that can contribute the most to your overall score.

Population Management: Document an individualized glycemic-treatment goal (that takes patient-specific factors into account and is reassessed annually) in 60 percent of medical records (year one) for outpatient Medicare beneficiaries with diabetes who are prescribed antidiabetic agents. If you are caring for a population of diabetic patients, you are doing this: providing patient-centered care; educating patients and families according to their social, cultural, and linguistic determinants; and regularly monitoring, evaluating, and modifying their care plans.

Beneficiary Engagement: Collection and follow up on patient experience and satisfaction data on beneficiary engagement, including development of all improvement plan. Whatever you are using – a postcard with four basic questions, an iPad at checkout, or an emailed survey – you are collecting information that affirms your efforts to meet the needs of your patients and their families on many levels. This information also may indicate areas for improvement. When you share the information with your staff and make changes to your processes, you are developing your improvement plan.

Patient Safety and Practice Assessment: Consult the Prescription Drug Monitoring Program prior to the issuance of a Controlled Substance Schedule II (CSII) opioid prescription that lasts more than three days (in California, the C.U.R.E.S. database). You have made this action a standard part of your patient assessment and treatment plan, thus protecting the patient, the community, and yourself. Consulting the PDMP in your state reflects your commitment to patient safety and appropriate prescribing.

continued on page 4

Continued from page 3

Let's circle back to the goal of taking credit for what you do best. Underlying IA, as well as the other MIPS categories, is our old friend, documentation. And documentation *is* our friend. Precise, accurate, and timely documentation builds a foundation of bedrock to stand on and refer to. Precise, accurate, and timely documentation proves our point, makes our case, helps us get paid, and sees us through audits.

The nine subcategories and 90 activities in the Improvement Activities category of MIPS offer us a chance to shine a bright light on the energy, intelligence, creativity, and commitment physicians and staff bring to the care of their patients, families, and communities. Identify what you do best, document what you do, and tell the world – or at least tell CMS.

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

Free eBook: The 8 Must-Haves for Your Medical Practice Website

Your medical practice website should be more than just a brochure: It should attract and engage patients, then get them to take the required action – namely, book an appointment. Does your website give you a competitive advantage over other physicians in your area?

To help our members, CAP offers you a free eBook, *The 8 Must-Haves for Your Medical Practice Website*. Request a copy at **CAPphysicians.com/yourwebsite.** In this eBook, you'll learn:

- Search optimization tips
- The importance of photography
- How to convert website visitors into patients

This free resource is brought to you by PatientPop, a premium, all-in-one solution for managing every aspect of your practice's online presence. For more information, please contact Jess Stricklin at 818-929-8361 or Jess@patientpop.com.

PatientPop is a featured benefit of CAPAdvantage, a program of CAP that offers members a suite of no-cost or competitively priced practice management benefits extending beyond our superior medical malpractice and risk management protection.

The Cooperative of American Physicians, Inc. and subsidiaries contract to receive compensation from certain product vendors as commissions or marketing fees. CAP uses these funds to control costs and provide additional services to its members.

Risk Management and Patient Safety News

It's Not What You Say, It's What Your Patients Hear

by Dona Constantine, RN

Doctor, do you feel O.U.T.? Overworked due to an increased patient load, Underpaid due to diminished reimbursement, and Told what to do because of too many rules and regulations such as the need to utilize an electronic medical record to capture data that will link patient satisfaction/experience with future payment models? As I relate the following story, keep in mind even educated people are vulnerable and often scared to visit a physician and the way things are said can affect patient satisfaction.

For approximately a year, while at work, a vibrant, healthy female attorney said she experienced upper back pain, which she attributed to tension, because it would go away once she got home. After several months, the pain became constant, but not debilitating. She continued to enjoy running, but after a few more months at the end of her run, she started feeling a tightening in her legs then dizziness set in.

She felt frightened and confused due to these unexplained symptoms, so she scheduled an appointment with her PCP. After some treatment options such as a referral to a neurologist, her PCP decided to order an MRI because "she might have a brain tumor." The PCP stated, "We'll get through this together." To which the patient thought to herself, "Will you be coming home with me to go through this with me?" As the day progressed, she kept thinking about the possibility of a brain tumor. This thought process triggered her first panic attack, for which she sought treatment at an emergency room.

Her appointment with the neurologist followed. He began by asking, "Why are you in so much pain?" The patient thought to herself, "That is why I'm here . . . to find out." After the exam, the neurologist said, "If you didn't have insurance, I'd send you home with anxiety medication, but because you do, let's run all these tests." She said that literally made her feel like the doctor thought she was making all this up and that she was crazy. Once home, she contacted good friends who surrounded her and validated her sanity.

Fortunately, there was no brain tumor, but another test revealed a cervical disc protrusion for which she is hoping a series of epidural injections will alleviate the pain.

Her experience with the way the physicians spoke prompted her to take someone along to each subsequent appointment to not only be a second set of ears, but also to assist in presenting her as a person so the doctors get a picture of how unusual this whole situation is for her.

Doctor, patients look to you to be competent and caring. They want to receive enough information to understand what you determine their issue(s) to be, what they need to do, why they need to do it, and what you recommend.

Remember . . .

"It's not what you say, it's what people hear."*

*Luntz, F. I. (2008) Words that work; it's not what you say it's what people hear.

Dona Constantine is a Senior Risk Management and Patient Safety Specialist for CAP. Questions or comments related to this article should be addressed to dconstantine@CAPphysicians.com.

Case of the Month

by Gordon Ownby

Transition Danger When Converting to Electronic Records

In London's Underground transit system, riders are warned to "Mind the Gap." In other words, step carefully when going between the platform and railcar. "Mind the Gap" is also good advice to medical offices moving from paper to electronic records.

A 63-year-old retired worker saw Dr. C, a cardiologist, on a referral from his internist after an electrocardiogram showed atrial fibrillation. Dr. C believed the fibrillation to be of recent onset and started the gentleman on amiodarone. On several visits to Dr. C over the next month, the patient's sinus rhythm had normalized and his amiodarone was decreased.

Visits to his PCP and to Dr. C some six months later included an isolated complaint of a rapid heart rate and a full feeling in his chest. He continued to take amiodarone, as well as daily aspirin. Various visits with his PCP over the next three years included discussions of atrial fibrillation and hypertension, plus other medical issues.

Six years on, the gentleman visited a hematologist for elevated hemoglobin. At one visit, the patient commented on occasional epigastric pain with activity. Concerned the symptom may be cardiac-related, the hematologist told the patient to return to Dr. C., which the patient eventually did, a year later.

On the patient's return visit, Dr. C put the patient on a Holter monitor and the next day had him perform a stress test/ECG. Dr. C's exercise echocardiographic report authored that second day stated that the patient was "being evaluated relative to the current status of his coronary anatomy, left ventricular function, and cardiac rhythm."

In that dictated report, Dr. C's impressions were: no chest pain with exercise, no significant ST changes or arrhythmias, normal left ventricle systolic function and response to exercise, and no evidence of myocardial ischemia. Dr. C considered the patient stable and advised him to return in three months.

Two months later, however, the patient suffered an embolic stroke, which resulted in facial droop and weakness in his left arm and leg. The patient and his wife sued Dr. C, alleging that he did not appropriately manage his atrial fibrillation.

During his deposition by the plaintiff's attorney, Dr. C testified that his focus on the patient's return to his office after the long absence was to rule out coronary disease, not to follow-up or rule out atrial fibrillation.

During that deposition, however, the plaintiff's attorney showed Dr. C a History and Physical Report from the first day of that consultation. That H&P, an electronically generated record (with Dr. C's electronic signature), stated at the outset: "The patient is a 70-year-old male who presents for evaluation and management of atrial fibrillation." The H&P also noted the patient thought he was having a recurrence of the fibrillation twice or three times a week.

Apparently, Dr. C's office was transitioning to electronic records at that time and the first day's History & Physical was the only record relating to the patient's care by Dr. C that was placed into the office's new electronic record. That electronic record was produced in the course of a copy-service request for the patient's chart made by the plaintiff's attorney prior to litigation. Dr. C resolved the litigation with the patient informally.

Risk managers advise that when transitioning to electronic records, both systems should be maintained until the new system is fully functional. Also, a special implementation team should oversee everything that is going on for at least a two-week period. And, of course, special care needs to be taken during the transition to make sure that no particular entry gets orphaned.

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

Will You Be Ready to Show Your HIPAA Risk Assessment?

by Jeff Mongelli

Getting audited by the Office for Civil Rights (OCR), the federal agency responsible for enforcing the Health Insurance Portability and Accountability Act (HIPAA), is becoming increasingly likely for medical professionals. Among the questions they will ask is, "Show me your risk assessment." Will you be ready?

Being prepared for a HIPAA audit is your responsibility. To gain a better understanding of what is expected of you as a Covered Entity, let's define what a Risk Assessment is and why it matters to you.

What Is a HIPAA Risk Assessment?

Risk assessments are nothing new. In fact, CAP's Risk Management team has likely worked with you in the recent past to evaluate and strengthen your risk management strategies. While this is helpful, the Risk Assessment requirements under HIPAA are very specific, and they have nothing to do with your medical malpractice risk that CAP is (properly) focused on. A HIPAA Risk Assessment covers five primary categories, detailed as follows: Administrative Safeguards, Physical Safeguards, Technical Safeguards, Organizational Requirements, and Policies and Procedures. The federal guidance for healthcare risk assessments was provided by the National Institute of Standards and Technology (NIST) as part of a risk management framework. Much like your taxes, you can do it yourself, or you can hire a professional compliance company to handle it for you. Most importantly, these Risk Assessments are not optional. You must conduct them – regularly and whenever anything changes organizationally, with your facility, or with your technology.

Why It Matters to You

Point 1 - Since the passage of the Omnibus Rule in 2013, the OCR has been defining and refining its auditing enforcement efforts. After an initial round of audits, they retooled and in 2016 began their Phase 2 round of audits. Phase 2 audit processes include random "desk" audits, where a letter is sent to a randomly selected entity. As stated by OCR, these audits will continue to capture a growing number of Covered Entities and Business Associates year after year.

Point 2 – Cyber-related risks are increasing at an exponential rate. Lax security controls, particularly where prized healthcare records are concerned, are almost a certain breach in waiting. As cyber criminals and their tools proliferate, and the healthcare industry continues to be target number one, it's become increasingly evident the only chance of protecting our personal health information is through increased diligence by industry stakeholders, even if motivated by the fear of federal penalties.

Point 3 – This year alone, as of the end of April, OCR has assessed a whopping $14.3 million in fines to small and large healthcare organizations. Ramping up their auditing and enforcement teams could generate well over $500 million annually for HHS if the current trend in rising cyber crime continues.

With increased risk and increased enforcement, waiting to conduct a Risk Assessment is flirting with financial disaster for your enterprise. Beyond the financial risk, the larger business risk includes the loss of trust of your patients and the damage to your reputation. After all, what provider wants to contact his or her patients informing them their entire personal identity, including their most personal health information, social security number, and/or other financial identifiers, has been stolen? You'll be required to do just that if you, or one of your Business Associates, experiences a breach.

CAP has partnered with Acentec to assist you with HIPAA compliance. Your CAP team has negotiated a substantial discount on our HIPAA Security Suite compliance process, including a thorough Risk Assessment. Contact us today at 800-970-0402 to get started.

Jeff Mongelli is CEO of Acentec, Inc., a nationwide provider of HIPAA compliance and medical IT management services. Questions about this article may be directed to jmongelli@acentec.com.

COOPERATIVE OF
AMERICAN PHYSICIANS

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

May 2017

IN THIS ISSUE

CAPsules® is a publication of the Corporate Communications Department of the Cooperative of American Physicians, Inc.
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.