THE MONTHLY PUBLICATION FOR CAP MEMBERS

CAPsules®

COOPERATIVE OF AMERICAN PHYSICIANS
CELEBRATING 40 YEARS OF SUPERIOR PROTECTION

CAP Publishes Second Edition of *Medicine on Trial*

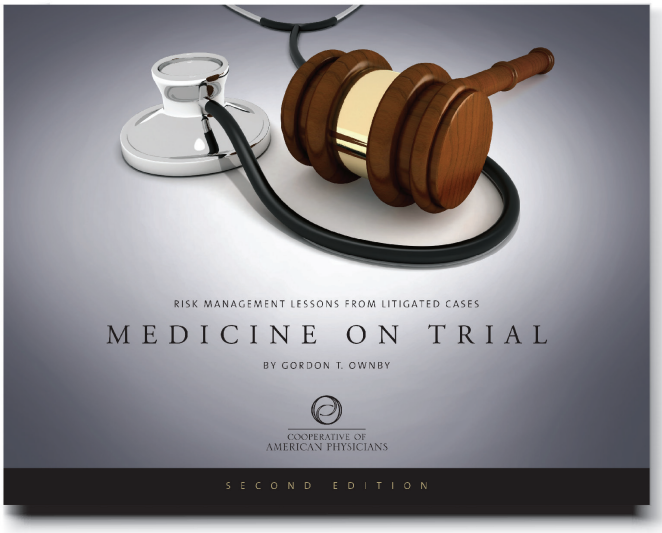
New compilation of litigated cases emphasizes risk management and patient education.

Seven years after the release of its highly popular *Medicine on Trial*, CAP has just published a second edition as an educational resource for our member physicians.

Inspired by the positive response to its original edition, *Medicine on Trial: Risk Management Lessons from Litigated Cases, Second Edition* is a compilation of more than 80 real-life, litigated cases, providing unique and meaningful insights into the experience of physicians who have been involved in court or arbitration disputes with their patients. Each case, accompanied by a commentary from CAP's General Counsel Gordon Ownby, sheds light on the various policies and routine procedures that physicians can implement to minimize risk in their own practices.

This comprehensive medical malpractice case reference, available as an impressive desktop book as well as in an electronic version, is offered to CAP members as a complimentary resource. It explains how physicians in private practice and hospital settings can better communicate with their patients, and each other, to mitigate risk. It also addresses topics such as dealing with challenging patients, adhering to patient rights and confidentiality requirements, end-of-life conversations, and much more.

"No healthcare provider wants to be embroiled in a legal dispute, but the reality is that – regardless of their commitment to employing best practices – most physicians will be sued for medical malpractice at least once during their lifetime," said Mr. Ownby. "By offering these real-world case studies, CAP is providing its members with the insight to build on those practices that improve medical outcomes and minimize risk."



CAP CEO Sarah Pacini added, "Today's physicians must practice expert medicine with a keen understanding of technology and law – and that can present myriad challenges. That's why CAP has built a formidable team of risk management specialists whose extensive acumen spans all facets of the healthcare and legal professions. Their expert consultations and guidance, paired with invaluable content offerings such as *Medicine on Trial*, continue to provide immeasurable value to CAP members."

To obtain an electronic version, send an email to communications@CAPphysicians.com.

November 2017

CAP Fellows Program – An Opportunity for You to Learn and Contribute

Are you interested in learning more about the CAP enterprise? Do you have the interest and time to serve your fellow members in this organization? CAP is looking for members who would like to participate in our Fellows Program.

The program is a year-long commitment that will begin in June. Selected fellows will have an opportunity to learn more about the organization and participate in a variety of committees throughout the year.

If you would like to learn more about the specific requirements, please send a current CV to cbelcher@CAPphysicians.com no later than December 31, 2017.

Save up to 40 Percent on Credit Card Processing Through New CAPAdvantage Program

If you are looking for a payment processing provider that is convenient, safe, and affordable, then meet BASYS: the newest organization to join the family of practice management vendors under our CAPAdvantage umbrella.

We selected BASYS to provide our members with customized credit card processing services that help them reduce costs and grow their businesses. Here are just a few of the key benefits to help you take the next step:

Great Rates

- You can save up to 40 percent on your current processing fees.
- BASYS will provide you a *free* savings analysis based on *your* business and the cards *you* accept (see details below).

Security

- Your business and your customers are protected from fraud with the latest encryption and tokenization technologies.

Customer Service

- When you call BASYS for help, a live person answers the phone within seven seconds.

- You will have a direct contact person at BASYS for questions and concerns.

For more information about BASYS' payment processing services, contact BASYS directly at 800-386-0711 or CAP@basyspro.com. BASYS is also happy to provide you with a free, no-obligation savings analysis for the asking. Email a copy of a recent statement from your current credit card processor to CAP@basyspro.com or fax it to 913-529-2329, noting you are a member of CAP.

And as always, you can contact CAPAdvantage Program Manager Sean O'Brien for questions you may have about this or any of our other valuable practice management programs. You may reach Sean directly at 213-473-8740 or sobrien@CAPphysicians.com.

Risk Management and Patient Safety News

New Data Dive Study: 'Leveraging Data: A Focused Review of Advanced Practice Professionals'

by Ann Whitehead, JD, RN

In this month's *CAPsules*, you will find a copy of the most recent CAP Risk Management and Patient Safety data study, "Leveraging Data: A Focused Review of Advanced Practice Professionals." Our data study and those of other national organizations, such as the PIAA and CRICO, indicate an increasing number of professional negligence claims involving advanced practice professionals (APP). This increase in liability is likely due to upward employment trends with increasing numbers of APPs in ambulatory healthcare settings. The goal of this study is to alert physicians to the most common risks of APPs and to provide guidance to identify systems issues and develop strategies for improvement.

Advance practice professionals provide an added benefit to any medical practice. Also, they are generally a low medical liability risk. Their employment allows busy physicians to focus on more complicated high-risk patients. For example, APPs who are nurse practitioners and physician assistants have more time to spend with patients and their families building rapport and increasing their overall satisfaction with care. These APPs enable patients to experience greater access to healthcare and reduced office wait times.

However, due to the sheer volume – not professional capabilities – of advance practice professionals in our members' offices, CAP anticipates an increased vulnerability to medical liability lawsuits. This data study of CAP Closed Claims concerning APPs allows members to understand common areas of medical liability risk; to identify contributing factors, such as poor communication and lack of supervision, that may negatively affect patient outcomes; and to pinpoint systems issues and proactively manage risk by implementing our recommended risk management strategies.

Over the last several years, the concept of patient safety in the office setting has gained greater focus. As we go forward with our data deep dive studies, lessons can be learned in the outpatient setting and important steps can be incorporated into your office safety plan to prevent events instead of relying on retrospective learnings from medical malpractice claims data. In this data study, we provide a case study, a list of the top five allegations against APPs, the most common risk management issues identified, emerging trends, and risk management strategies to improve patient outcomes.

CAP risk management staff evaluated 42 (n=42) closed claims for the six-year period of 2011 through 2016 involving APPs resulting in an indemnity payment. The average indemnity paid was $223,149 and, in most cases, was made on behalf of the supervising physician's medical professional liability coverage (MPL). The study found the top five allegations against APPs were: Improper Management of Course of Treatment, Failure to Refer/Seek Consultation, Failure to Manage Pregnancy, Failure to Diagnose, and Improper Management of Medication Regime. When we looked at the contributing factors for these cases we found: lack of supervision, lack of clinical judgment, communication failure, and poor documentation.

continued on page 4

Continued from page 3

Actively addressing these contributory factors should be a goal for physicians and office managers. Interventions to reduce ineffective communication and lack of supervision are listed in the risk strategy section of the study.

We hope you find the Risk Management and Patient Safety Data Dive periodical, "Leveraging Data: A Focused Review of Advanced Practice Professionals," informative and useful to ensure that your APPs are qualified, competent, and knowledgeable. It is our hope that this data study will provide physicians with information and insights that will encourage process improvement and change resulting in improved patient safety.

We encourage member physicians to review the CAP website and references provided on the back page of the study. CAP's risk management and patient safety staff is available to discuss ways to implement the risk strategies listed and to assist with systems process improvement challenges.

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.

Is Your Most Valuable Asset Protected From the Unexpected?

Are you sure you have enough to protect your most important asset – *you*?

At CAP Physicians Insurance Agency, Inc., our goal is to help doctors protect all of their assets. These assets range from your practice to your home and car. So what would happen if you became too sick or hurt to work? How would you afford all of the things your income pays for?

Disability Insurance protects your income so if you become hurt or sick and cannot work, you will still get a monthly benefit to pay for all those things in your life.

Group Long Term Disability Benefits cover about 60 percent of your gross income and is based on your income when you apply. It will also offset for certain types of other benefits such as State and Social Security Disability.

Older generation individual policies limited the amount of coverage you could purchase and they may not adequately cover you if you were not able to work. Even if you already have a disability policy, such as group long-term disability insurance, or you purchased an individual policy many years ago, that's a great start, but is it enough for you to keep up your current lifestyle and financial goals?

A separate individual disability insurance policy is a great way to fill potential gaps in protecting your income. It's one of the most common components of a strong financial plan because it's so important. Experts agree: making that small investment today helps ensure you and your family are taken care of if the unexpected happens in the future.

Getting an additional $5,000 a month of coverage could be as easy as completing a short application and a telephone interview using accelerated underwriting guidelines.

CAP's Insurance Agency is here to assist you to make sure your most valuable asset is protected. Call Janet Hemphill at 213-473-8643 or email jhemphill@CAPphysicians.com at CAP Physicians Insurance Agency for a free quote today.

An Old Model Seeks Innovation

by Gabriela Villanueva

A rarely mentioned entity that was created by language in the Affordable Care Act (ACA) is the Center for Medicare & Medicaid Innovation (CMMI), housed within the Centers for Medicare & Medicaid Services (CMS). The Innovation Center's principal task is, as its title declares, to develop and test innovative healthcare payment and service delivery models with the goal of lowering costs through improvements to the healthcare system. As an example of this, CMMI has played a critical role in implementing the Quality Payment Program (QPP), which Congress created as part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA).

Policy changes can come about outside of the congressional legislative process through the creation and implementation of regulations, something that the current administration is looking to utilize via the CMMI to reintroduce a Medicare reform model long favored by Republican policymakers.

In a "premium support model," as it is commonly known, the federal government would provide a payment on behalf of each Medicare patient toward the purchase of a health insurance plan – either a private plan, a similar Medicare Advantage plan, or traditional Medicare. Under this system, health plans would compete for enrollees and people on Medicare would choose among plans for their coverage, as they currently do, but with the key difference that payments for services provided would be capitated rather than the current approach of tying payments to the specific services that patients use. This method has also been called a defined contribution or a voucher approach. (It is important to note that the capitated payment would be to the health plan and not the physician who bills Medicare directly. Physicians and physician groups who bill Medicare are under QPP regulations).

This idea is not entirely new, as it has made prior appearances as far back as 2011 in multiple legislative proposals by senators such as Lindsey Graham (R-SC), Richard Burr (R-NC), Tom Coburn (R-OK), House Representative Rand Paul (R-KY), and most recently in policies outlined in Speaker Ryan's "A Better Way" plan in 2016.

The Health and Human Services Department (HHS) is beginning to set its policy agenda for CMMI after presenting a proposal on September 20 seeking input from stakeholders on various ideas such as premium support, physician private contracting with patients and balance billing, and value-based purchasing contracts for prescription drugs. Stacy Sanders, federal policy director at the Medicare Rights Center, said she is "concerned about the proposals whether or not they fit the requirements laid out in the statue authorizing CMMI. A model has to either save money and maintain the same or better level of care quality, or keep spending neutral and improve quality."

For information on the CMMI, visit https://innovation.cms.gov/initiatives/direction/.

Gabriela Villanueva is CAP's Public Affairs Coordinator. Questions or comments related to this article should be directed to gvillanueva@CAPphysicians.com.

CAP Bylaws and MPT Agreement Amendments; Board Election Results

By the vote of the membership on July 27, 2017, the Cooperative of American Physicians Bylaws and the Mutual Protection Agreement have been amended.

Article 4.2.2 and Article 6.7 of the CAP Bylaws and Part 2, Section 1.B and Section 1.G.1(a) of the MPT Agreement have been amended to limit service on the CAP Board of Directors and the MPT Board of Trustees to 12 years and to limit service of a board chair to four years.

Part 1, Section 1 of the MPT Agreement has been amended to clarify that MPT will cover a claim that was first brought during a Member's coverage period or during the member's tail coverage period.

Part 2, Section 7.J of the MPT Agreement has been amended to modify the MPT Agreement's reference to the CAP and MPT Statement of Privacy Obligations and to include website publication as a method of delivering the Statement to members.

Full versions of the CAP Bylaws and the MPT Agreement are available to members by logging in at www.CAPphysicians.com.

As previously announced via email to members and website publication, the following CAP Board of Directors were elected to two-year terms: Sheilah Clayton, MD; Béla S. Kenessey, MD; Wayne Kleinman, MD; Gregory Lizer, MD; Amir Moradi, MD; Graham Purcell, MD; and Paul Weber, MD.

Because election of MPT Trustees requires an affirmative vote of a majority of all members and because no candidate received the required vote, the current trustees, Mearl Naponic, MD; Othella Owens, MD; Andrew Sew Hoy, MD; Charles Steinmann, MD; and Phillip Unger, MD, will remain in office until their successors are elected.

Public Policy

Still Confused About MACRA and Its Quality Payment Programs? CAP and HSAG to the Rescue!

If you're still trying to navigate MACRA's Quality Payment Program (QPP), including MIPS, you are not alone: Many physicians have been delaying or completely avoiding participating in the QPP, not only because of the complexities of the program, but because of its frequent changes. The good news is there's plenty of help out there and we're here to point you in the right direction.

Over the past several months, CAP has been working closely with the nonprofit Health Services Advisory Group (HSAG) to help our members gain a better understanding of QPP to help maximize reimbursement. In early 2017, the Centers for Medicare & Medicaid Services (CMS) awarded contracts to community-based organizations throughout the country, including HSAG, to fund on-the-ground QPP training and education to clinicians in individual or small group practices.

The following are some of the valuable no-cost benefits CAP members can take advantage of through HSAG's Quality Payment Program Services Center:

1. One-on-one technical assistance to help you select the best quality measures for your practice.
2. Telephone support at 844-472-4227 to speak with a QPP specialist.
3. Email support for any questions you may have. Typical response is one business day.
4. Learning Forum Fridays, a series of weekly educational webinars.
5. Other tools and resources featured on the HSAG website.

To contact HSAG to register to receive no-cost technical assistance, visit www.HSAG.com or call 844-472-4227.

In addition, CAP is maintaining a robust MACRA resource center on our website (www.CAPphysicians.com/MACRA) that includes an updated version of the informative MACRA white paper, latest updates from CMS, and more.

We hope you take advantage of the tools and resources that HSAG and CAP have to offer to help ease the burden of payer reimbursement.

The Successful Physician

by Carole A. Lambert, MPA, RN

Everything Old Is New Again

As the year winds down, we have been organizing files and reflecting on the colleagues we have met, the programs we have attended, and the presentations we have given. The theme that runs throughout the year – and will probably continue into 2018 – is that everything old is new again. As we work together to support CAP physician members and their staff, and the wider community beyond CAP, we inevitably talk about accepting and mitigating risk. In collaboration with Randie Minovitz, BSN, RN, from PIH Health Whittier (and a CAP alumna), we developed a presentation, "Risk Management Forever – Because Everything Old Is New Again." Here is a summary of what we spoke about:

The healthcare delivery landscape continues to evolve with uncertainty the only constant. Every aspect of a physician's practice – patients and their families, staff, suppliers, hospitals – is buffeted by competing and sometimes contradictory demands. The hurdles we face include:

- Working within and clarifying new and unfamiliar structures
- Interpreting a new taxonomy/lexicon/data/analytics
- Anticipating and responding to new and unexpected challenges
- Educating, modeling, mentoring, and translating for a new generation of colleagues

As we meet with and hear from physicians and their staff, they are very clear about their purpose. They believe we need to keep our shared goals and objectives in sharp focus. When all is said and done, what we really want is:

- Patient safety
- Physician safety
- Staff safety
- Organizational safety

In pursuit of these goals and objectives, our work calls on us to mobilize our very real strengths :

- Flexibility
- Organizational savvy and influence
- Communication, communication, communication
- Persistence and ability to overcome resistance

We build on a solid foundation of time-tested elements that are much more than a checklist at which we roll our eyes and smile.

- Communication
- Documentation
- Follow up and follow through
- Medication reconciliation
- Informed consent
- Transitions of care

These elements constitute a strategy for providing patient and family-centered coordinated care that makes the most effective use of the resources we have to offer. They are timeless classics, and they will never go out of style.

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

Case of the Month

by Gordon Ownby

Courts Make Another Attempt to Clarify Classification of Medical Office Injuries

Writing another chapter in the courts' long-running narrative over how to characterize certain types of medical facility injuries, a new case offers guidance on whether such injuries are governed by California's Medical Injury Compensation Reform Act (MICRA).

Patient Claudia Johnson was in a medical clinic reviewing test results with a nurse-practitioner after having her vital signs taken and getting weighed on a scale located against the wall in the hallway outside the treatment room. On her way out of the treatment room after learning that her results were satisfactory, the patient tripped on the scale, which she alleges was moved during the consult and was partially obstructing the path from the room to the hall. The patient suffered serious injuries in the fall.

When the patient filed a suit against the clinic nearly two years later, the clinic sought a dismissal based on MICRA's one-year limit for filing suits arising out of an alleged "negligent act or omission to act by a health care provider in the rendering of professional services." Though the plaintiff argued that a two-year limit applied for general negligence (as opposed to medical negligence), the trial court found for the clinic and dismissed the suit.

On appeal, the Court of Appeal in *Johnson v. Open Door Community Health Centers* used a recent California Supreme Court Case, *Flores v. Presbyterian Intercommunity Hospital*, to distinguish between a healthcare provider's duty to a patient versus a duty owed to the general public. In *Flores*, the state high court found that a hospital owed a medical duty to a patient as a healthcare provider for a patient's injury arising out of improper maintenance of a bed's guard rails.

"Unlike plaintiff Flores, who was injured during the provision of medical care, through the breach of a duty owed only to patients, Johnson was injured after her care was completed, allegedly as a result of a breach of duties owed generally to all visitors to the Open Door Clinic."

In making its ruling, the Northern California-based Court of Appeal took a moment to explain that the provision of "professional services" under MICRA is not limited to those activities requiring the application of medical skill and training:

"Injury-causing conduct that requires no special skill may nonetheless occur in the rendering of professional services, for example, when a janitor accidentally bumps a patient's ventilator; a hospital employee accidentally serves a patient food that is not part of the patient's medically-prescribed diet; or a hospital fails to adequately secure a violently coughing patient awaiting a diagnosis."

Important to the Court of Appeal in the *Johnson* case, however, was the plaintiff's allegation that the clinic's placement of the scale posed a tripping hazard, implicating the clinic's duty to maintain a safe premises for all users, including patients, employees, and other invitees.

"Under these circumstances, the nature of the object does not matter – the scale could have just as easily

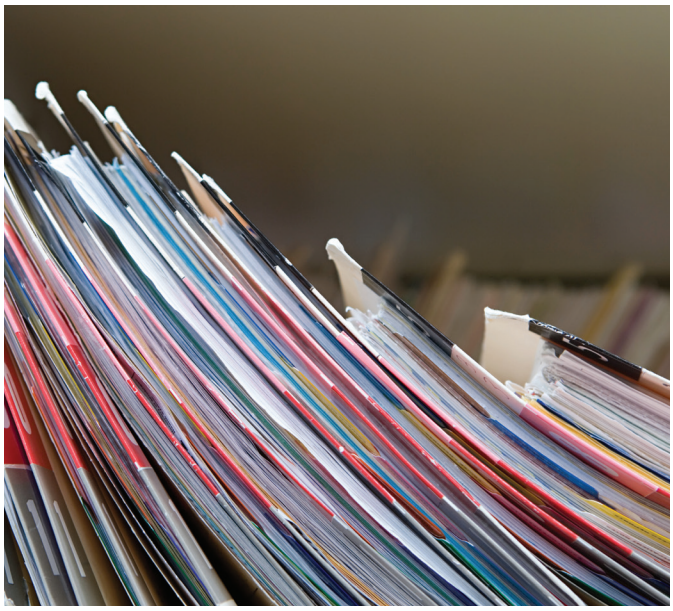
continued on page 9

Continued from page 8

been a broom or a box of medical supplies – what is material is that the duty owed by Open Door was not owed exclusively to patients," the court said.

Borrowing language from *Flores*, the Court of Appeal concluded: "Because Johnson's injuries resulted from an alleged breach of defendant's obligation, 'simply by virtue of operating facilities open to the public, to maintain [its] premises in a manner that preserves the well-being and safety of all users,' the trial court erred in applying MICRA's one-year statute of limitations."

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



CyberSecurity for CAP Members

November 2017

Cyber criminals have stolen 143 million credit records in the recent hacking scandal at Equifax. The information that was taken was highly personal information that can be used to trick you. Although the Equifax breach was directed more at individuals, the information acquired can now be used to obtain information to breach your practice.

It is more important than ever to be diligent regarding your data security. Be on the lookout for phishing emails that claim to be from Equifax directing you to check if your data was compromised. If one of your employees receives one of these emails, will he or she be able to recognize it is a scam or a way to breach your system?

CAP provides a CyberRisk policy for all of its members that will assist them if the practice were to experience a data breach. One of the benefits of this policy is access to NAS Cybernet website. This website may be accessed through your CAP membership and provides you with up-to-date information on preventing data breaches as well as access to free online HIPAA training with a certification document to show completion. Additionally, there are classes such as Introduction to Breaches, Data Security Basics, and Social Engineering. You can even assess your Cyber Resilience and get a

risk rating with recommendations to improve your security posture.

As the exposure to this type of risk continues to increase, CAP Physicians Insurance Agency, Inc. is here and ready to help answer your questions and guide you. Call one of our insurance professionals at CAP for a free, no-obligation quote for a higher limit policy. The surprise will be how low the cost is for the peace of mind that your practice is covered. You can contact CAP Agency by emailing capagency@CAPphysicians.com or call them at 800-819-0061.

COOPERATIVE OF
AMERICAN PHYSICIANS

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COOPERATIVE OF AMERICAN PHYSICIANS

Risk Management & Patient Safety Data Dive

SEPTEMBER 2017

LEVERAGING DATA:

A Focused Review of Advanced Practice Professionals

by Amy McLain, BSN, RN

Failure to Diagnose and Treat Fulminant Bacterial Infection: Patient Disfigured and Disabled

A 57-year-old diabetic male laborer (DM) presented to a busy general practice office complaining of throbbing right foot pain, 8 on a scale of 1-10, with tenderness to touch, swelling, and an inability to bear weight. While at work the previous day, DM slipped from a squatting/kneeling position and caused the tip of his steel-toed work boot to hyper-flex and dig into the top of his right foot.

Office protocol required a physician to see DM at his initial visit. However, the physician was busy and DM was seen by the physician assistant (PA). PA's exam revealed moderate swelling and erythema, slight ecchymosis on the right dorsum mid-foot extending distally to all toes. The dorsalis pedal pulse was palpable. His nail beds had good capillary refill. X-rays of the foot and ankle were normal.

DM was prescribed Toradol 60mg IM, Ibuprofen, and Vicodin for pain. He was given a cold pack, crutches, and an open-toed shoe. Instructions included elevating his right leg and returning to the clinic in 2 days.

DM returned to the clinic two days later, as instructed, and was seen by the physician (MD). DM's pain is constant and now a 10. BP = 140/70. Pulse = 80. MD's exam revealed ecchymosis, severe swelling, and erythema of the right foot with proximal streaking upward to the knee. A diminished pedal pulse, hypoesthesia, and superficial de-vascularization of the skin were noted. MD diagnosed severe cellulitis with lymphangitis of the right foot and instructed DM to go to the ER STAT.

At the emergency room, DM tells the ER physician (ER) that he had a cut on his foot and developed a fever of 102 the prior day. WBC is 20,000. ER discovered a small laceration on DM's right foot, most likely occurring at the time of the injury. DM was diagnosed with a wound infection. Infectious Disease and Podiatry was consulted.

DM was admitted to the hospital that same day and scheduled for a surgical debridement. The surgeon found a sinus tract extending from the dorsum of DM's right foot progressing upward towards his ankle with liquefactive necrosis of the extensor digitorum muscle and purulent drainage -- Necrotizing Fasciitis.

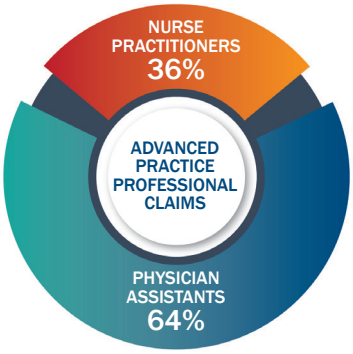
DM experienced an extended hospital stay. He received IV antibiotics, underwent two more debridement surgeries, and needed a skin grafting. DM now wears a foot brace, orthotic shoes, and walks with a cane leaving him unable to work.

Settled for $450,000!

In This Data Study...

Employment trends indicate an increasing number of Advanced Practice Professionals (APP), specifically Nurse Practitioners and Physician Assistants, in healthcare settings. Correspondingly, CAP physicians will be more vulnerable to lawsuits due to the sheer number of these mid-level providers that they supervise. Therefore, CAP risk management staff evaluated forty-two (n=42) closed claims from 1/1/11 through 12/31/16 involving Advanced Practice Professionals. The sole purpose was to identify trends and to develop strategies for our members and their APP's that will improve patient care and reduce medical liability. This is what we found...

TOTAL CLAIMS REVIEWED	42
TOTAL INDEMNITY	$11,896,829
TOTAL EXPENSES	$2,311,847
TOTAL INCURRED	$14,208,676



Of the 42 CAP claims reviewed, Physician Assistants were sued nearly double the frequency as Nurse Practitioners. Our findings mirror an extensive study done by the Federation of State Medical Boards (NPDB).

AVERAGE INDEMNITY	$223,149

*PIAA (2006) Average Indemnity $228,547

AVERAGE EXPENSES	$55,044

Data results continue on pages 2-3.

The Rest of the Story…

Decisions made during the patient's initial visit resulted in some missed opportunities. DM had disclosed his diabetes on the H&P, yet the PA's exam was limited to the work-related injury. The PA did not inquire about diabetic complications. No test for peripheral neuropathy was conducted. A blood glucose test was not performed. And, the PA did not consult or refer with the supervising physician. At trial, experts testified that the PA should have appreciated DM's increased risk for cellulitis and vasculopathy. It was their opinion that even in the absence of a laceration, it was necessary to prescribe prophylactic antibiotics to this patient. They believed that the PA did not recognize the presence of an infection or he/she would have treated it.

Further complicating defense was deficient documentation in the medical record. There was no mention of diabetes in visit progress notes. No temperature was recorded. The PA did not address the appearance and integrity of the patient's skin – an important aspect of assessing a diabetic patient. And, there was no proof that the patient received any follow-up instructions to return to clinic before the return appointment, if symptoms worsened. Additionally, there was a glitch in the EHR system. The diagnosis of cellulitis with lymphangitis made by the MD at DM's second office visit had auto-filled in to the PA's office visit note. This created a challenge to the integrity of medical record.

DM may have had a better outcome had the PA conducted a more thorough H&P and physical examination, ordered prophylactic antibiotics, and informed the patient to return sooner than his appointment date for specific worsening symptoms. In addition, the following strategies may have prevented the patient's injury and improved defense:

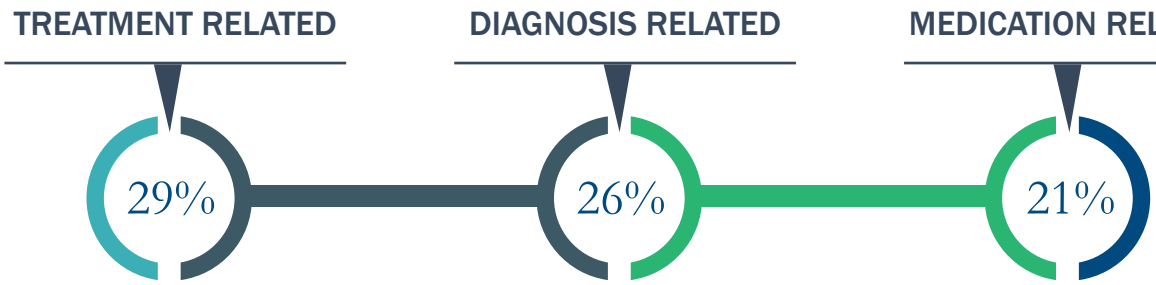
- Review the patient-completed H&P and address deviations from normal.
- Order necessary diagnostic tests to confirm or eliminate diagnoses.
- Contemporaneously document clinical findings, provider actions, and patient discussions/ responses to care.
- Never leave blanks or unfilled data spaces in the EHR/medical record.
- Provide patient with written educational materials and follow-up instructions.
- Adhere to protocols and collaborate with supervising physician.

Please see Risk Management Best Practices on page 4 for more risk reduction strategies.

Generally, nurse practitioners and physician assistants are a lower malpractice risk than physicians.

Their employment improves patient access to care and allows physicians to spend more time treating complex, high-risk patients. However, they are not a replacement for physicians- they are an agent of the physician. Physicians are responsible for the delegation of medical services to APPs, but they don't always understand their role in supervising their nurse practitioner or physician assistant.

Top 3 Allegation Categories



- Most common patient allegations:
  - Improper Management of Course of Treatment
  - Failure to Refer/Seek Consultation
  - Failure to Manage Pregnancy
- Most common patient allegation:
  - Failure to Diagnose
- Most common patient allegation:
  - Improper Management of Medication Regime

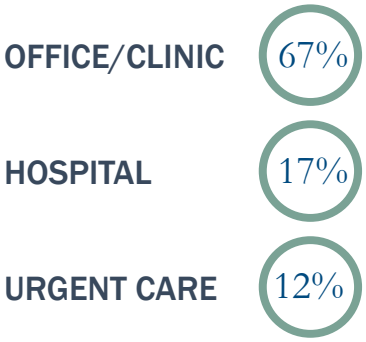
Of the 42 cases reviewed, the top 5 patient allegations (listed above) made up nearly half (47%) of the claims. Except for Failure to Manage Pregnancy, these patient allegations appeared most often in cases where patients were later diagnosed or treated for infections or fractures.

Warning: A Trend Emerges…

After reviewing the 42 cases, it became apparent that an adult patient with co-morbidities, such as diabetes mellitus, heart disease, and obesity and who presents to a medical office/clinic complaining of symptoms associated with an infection or fracture, is at greater risk for a poor outcome. The risk increases when the patient is non-compliant or non-adherent to their recommended medical regimen and have language barriers. Furthermore, these complex patients are usually treated for the same/similar issues over numerous visits by multiple healthcare providers, both advanced practice professionals and physicians, potentiating a problem with provider communication and follow-up. No one really knows the patient's full story or who's doing what, especially if there is poor documentation in the medical record.

In 59% of the cases, errors occurred during patient examination, the management of medication, and with follow-up. Frequently, the APP did not conduct a thorough enough physical exam or obtain important vital signs. They often relied on the patient's subjective complaints or were dependent on the previous provider's notes for diagnosis and treatment. Necessary diagnostic tests, such as an AFP or x-rays, were not ordered and acted upon. Medications were prescribed or changed without first consulting with the supervising physician. And, many patients fell through the proverbial cracks by not receiving adequate verbal or written information about referrals to specialists or when to return to the clinic.

Claims Based on Location



Claims Based on Specialty

Risk Management Best Practices

Building a strong foundation in excellent care and patient safety begins with ensuring that the APP is qualified, competent, and knowledgeable of his or her role. CAP recommends the following risk management strategies to reduce medical liability:

Employment – *Take your time when hiring a Nurse Practitioner (NP) or Physician Assistant (PA).*

- Evaluate credentials: verify graduation from an accredited program and active licensure. NPs are licensed by the CA Board of Registered Nursing. PAs are licensed by the Physician Assistant Board, a division of the Medical Board of CA.
- Perform background checks, including criminal and professional board actions.
- Verify professional liability coverage and obtain a copy of current policy. Investigate malpractice claims history with the National Practitioner's Data Bank (NPDB).
- Contact all references, including past supervising physicians and coworkers; even those not listed on resume.

Education and Training – *Play an essential role in mentoring and foster their educational development. Recognize that no two APPs are created equal--each professional has a unique skills set and level of experience.*

- Utilize skill checklists to determine areas of competency and deficiencies.
- Provide ongoing on-the-job training, especially for those new to practice. Longer training time may be needed if the APP is working in a group setting with multiple physicians. Experienced APPs will benefit from an orientation where performance expectations and practice standards are clarified.
- Support professional growth and need for continuing education. Consider topics relevant to clinical practice--communication, empathy, managing patient expectations, and improving patient satisfaction.

Comprehensive Written Protocols – *Liability can be mitigated by tighter adherence to clinic guidelines.*

- Understand state laws and regulations that define the APPs scope of practice.
- Clearly define their role in a written job description within the Standardized Procedures and Protocols (SPP) for the NP or the Delegation of Services Agreement (DSA) for the PA.
- Define their scope of practice. Protocols should outline the types of patients the APP can manage independently, the treatments they can provide, the type of drugs they can prescribe, and the types of procedures they can perform.
- Exemplify the types of problems, conditions, and clinical complaints that require real-time consultation with a physician and referral to a specialist.

These two categories of interventions can directly improve patient outcomes and prevent problems associated with ineffective communication and the lack of supervision further reducing medical liability.

Collaborative Relationship – *Patients' lives depend on effective communication and teamwork.*

- Create a "culture of safety:" encourage open communication and value good internal relationships; invite consultation; be available and approachable—your APP will feel more comfortable asking important clinical questions and seeking your guidance and involvement in patient care.
- Prioritize provider well-being and participation in quality improvement and workplace changes. Research solidly correlates a clinician's job satisfaction with favorable patient outcomes and improved patient satisfaction.

Supervision – *Don't be left out of the loop! Understand your role as supervisor.*

- Understand state laws and regulations; recognize that legal regulations are the minimal requirement.
- Conduct frequent meetings to discuss patient care, review charts, resolve conflicts, and reinforce policies and procedures.
- Maintain records of periodic performance evaluations and chart reviews in personnel files.
- Document all consultations with the APP--a simple note in the chart is sufficient.

Tools and Resources:

CAP website
www.capphysicians.com

The Medical Board of CA
www.mbc.ca.gov

CA Board of Registered Nursing
www.rn.ca.gov

Department of Consumer Affair's Physician Assistant Board
www.pac.ca.gov

The National Practitioners Data Bank
www.npdb.hrsa.gov

Cooperative of American Physicians, Inc.

333 South Hope Street, 8th Floor
Los Angeles, California 90071

General: 800-252-7706
Hotline: 800-252-0555
Email: riskmanagement@CAPphysicians.com

COOPERATIVE OF AMERICAN PHYSICIANS