COOPERATIVE OF
AMERICAN PHYSICIANS

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

November 2015

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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

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THE MONTHLY PUBLICATION FOR CAP MEMBERS

CAPsules

COOPERATIVE OF AMERICAN PHYSICIANS

November 2015

Howard Krauss, MD, Neurosurgical Ophthalmologist; Member of the Medical Board of California

Physician Response to Industry Pressures, Mandates Key to Survival, says CAP Member

At a recent presentation – 'Physician Whither Thou Goest' – Dr. Howard Krauss says the physician-patient relationship must prevail over the provider-enrollee encounter.

The world has witnessed many remarkable and hard-to-foresee changes since the Hippocratic Oath. However, the principle that "with regard to healing the sick (…) I will take care that they suffer no hurt or damage" remains at the core of caring medicine.

Whether that physician-patient relationship prevails depends largely on how doctors respond to today's intensifying pressures.

This was the thesis of the presentation Dr. Howard Krauss delivered at The St. John's Physicians Alumni Association on October 15, 2015.

"We face a tsunami of issues," Dr. Krauss noted, "ranging from the Patient Protection Affordable Care Act and Pay-for-Performance to for-profit mega health plans, but if we and our professional organizations do not protect our patients, then we do not deserve to be protected."

"The physician has been and must continue to be, first and foremost, the chief advocate for the well-being of his or her patient," Dr. Krauss urged. "It's our duty to maintain personal excellence and to promote adherence to standards of medical care as established by a physician community which is dedicated to the well-being of patients."

Medicare and other third party payer payment differentials – in association with ever increasingly expensive compliance with evolving regulations – are driving solo practice doctors and small groups into large healthcare systems. As Dr. Krauss put it, "This risks drastically increasing the costs of service and reigning in physician autonomy."

While there are powerful pressures from all sides now, physicians are the ones who know what excellent health care is. The physician and the physician community must hold the high ground and insist that the need for a healthy corporate balance sheet cannot outweigh the health needs of their patients, Dr. Krauss insists.

"Government, administrators, and payors need to trust that we will sensibly stand up against anything that might sacrifice the well-being of a patient," said Dr. Krauss. "If we fail in that duty, we may do harm in the name of 'cost-containment' or 'shareholder profit.' "

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DR. HOWARD KRAUSS AT-A-GLANCE

Medical Specialty: Neurosurgical Ophthalmologist

Practice Location: Los Angeles

CAP Member Since: 2003

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What's more, the future of medicine is not something that can be taken for granted.

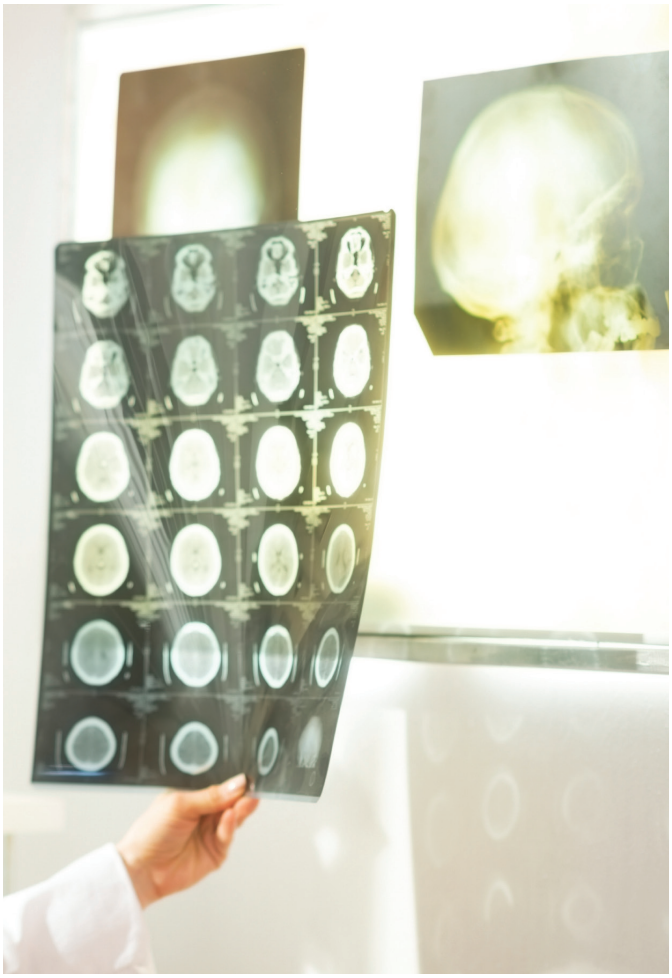
"What will happen," asked Dr. Krauss, "if there are no more doctors, but only 'providers'?"

Dr. Krauss continued with a deliberately faniciful, tongue-in-cheek tale. "Imagine walking into a facility in pain and being greeted by someone saying, 'Hello, my name is Larry. I'll be your healthcare provider today… Would you like to hear about our specials?' And then, before you can answer, an announcement comes over the PA: 'Attention shoppers, for the next two hours only, there is a blue light special on aisle 9 – have your colonoscopy today and receive a coupon for 50 percent off any routine preventative healthcare procedure for you or a loved one, good for one year from date of issue!' "

Dr. Krauss' story was told with his usual disarming sense of humor, but make no mistake: His underlying message is a serious one. Medicare and other third-party payer payment differentials -- in association with ever increasingly expensive compliance with evolving regulations -- are driving solo practice doctors and small groups into large healthcare systems. As Dr. Krauss put it, "This risks drastically increasing the costs of service and reigning in physician autonomy."

And there are still more looming questions. "Will the IPAB (Independent Payment Advisory Board) be constituted? Will 'data' analysis of ICD-10, CPT-coded encounters, and 'outcomes' lead to government or third-party payer mandated protocols of care?" Dr. Krauss asked the group. "Are 'quality indicators' already being designed and utilized by government and third-party payers as tools of coercion of physician behavior?"

As with all endeavors in 2015, medicine is also profoundly impacted by new technologies and new applications of existing technologies. The evolving roles of mHealth and telehealth are still being defined. Last year saw the launch of IBM Watson Health, and its $700 million dollar acquisition of Merge Healthcare is, as *The Wall Street Journal* noted, "a crucial step in its plan to put artificial intelligence to use in medicine."



Yet with all these changes – and in many ways, because of these changes, physicians have to take more care than ever to ensure that they keep their patients' care foremost in their minds.

The pressures are real, but so are the responsibilities.

Dr. Krauss closed his presentation with these inspiring words, "My dear colleagues: It's up to you. Will you fight for excellence? Will you create the future of health care, or will you fall victim to it?"

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- A scribe's notes may help reduce the use of previously used transcription services.
- Improved documentation also may help achieve "meaningful use" incentive criteria by allowing for improved compliance with quality measures for billing and reimbursement.

The good news is an increasing body of research is showing the use of medical scribes has been shown to improve physician/LIP productivity, cost and time savings, better patient satisfaction, and patient safety, especially when the physician/LIP is not electronically savvy and data entry causes fatigue and dissatisfaction.

Susan Jones is a Senior Risk Management & Patient Safety Specialist for the Cooperative of American Physicians, Inc. Questions or comments related to this article should be directed to sjones@capphysicians.com.

Legislature, Agencies Work on CURES

MICRA

Though the recently concluded California legislative session did not produce any MICRA-related bills, two pieces of legislation did address physician use of the state's prescription drug database – a subject of sharp debate during last year's battle over Proposition 46.

That proposition, which would have quadrupled the limits on awards for noneconomic losses under California's Medical Injury Compensation Reform Act (MICRA), included an additional provision to immediately mandate physician use of the state's Controlled Substance Utilization Review and Evaluation System, better known as CURES. Introduced in the just-concluded session by Sen. Ricardo Lara (D-Bell Gardens), SB 482 closely resembled the language in Prop. 46 to require prescribers to consult the database when prescribing a Schedule II or III drug to a patient for the first time. The bill was held up by the author this session but is likely to be reintroduced in 2016.

The Department of Justice and the Department of Consumer Affairs have been working to upgrade CURES, and in June announced the soft launch and phased rollouts of what they are calling CURES 2.0. To access the database, medical personnel must be registered with the system. Currently, physician registration is voluntary, but a bill passed in 2013 required all doctors to register with the system by January 1, 2016.

Because of the acknowledged concerns regarding the current robustness of CURES, AB 679 by Assemblymember

Travis Allen (R-Huntington Beach) has extended that deadline to July 1, 2016. According to the state Department of Justice website, www.doj.ca.gov, the "universal adoption of CURES 2.0 will take place soon, affording an automated registration process for new applicants." The passage of AB 679 not only provides an extension that will allow the DOJ to fully roll out the automated registration process, but also offers protection for doctors from discipline by the Medical Board of California during the system roll-out.

More information on CURES can be found at:
https://oag.ca.gov/cures-pdmp
https://pmp.doj.ca.gov/pmpreg/RegistrationType_input.action

Contacts for CURES information include cures@doj.ca.gov and (916) 227-3843.

Ahhh... the Beauty of a Scribe

by Susan Jones

Medical scribes have been around for a while but are now starting to receive increased attention in the healthcare industry as many more practitioners are turning to their use. With the now commonplace use of EMR/EHR systems to help practitioners stay focus on giving quality patient care and relieve the practitioner from the burden of having to chart patient encounters that are requiring more detailed documentation.

A scribe is an unlicensed person hired to enter information into the EMR or paper chart at the direction of a physician or Licensed Independent Practitioner (LIP), for example a nurse practitioner or physician assistant. The Joint Commission's (TJC) stand is that they do not endorse nor prohibit the use of scribes. However, if the organization using a scribe is subject to TJC surveys, the surveyors will expect to see compliance with applicable JC standards. Additionally, TJC's stand is that a scribe does not and may not act independently and does not support scribes being utilized to enter orders for physicians or LIPs due to the additional risk involved in the process.

Overall Roles and Responsibilities of a Scribe

A scribe's core responsibility is to capture accurate and detailed documentation of the provider encounter. Scribes are clerical personnel who chart for the provider and do not interview or have direct contact with patients. Scribes may not make independent decisions nor translate while entering information into the patient's health record beyond what is directed by the provider.

It is not recommended to allow an individual to be both a scribe and a medical/clinical assistant during the same encounter as this practice raises issues of job role and responsibility (i.e., scribes have pretty much the same HIPAA security rights as a provider, while a medical/clinical assistant may have limited access to a patient chart based on their scope of practice.)

Documentation Guidelines (per the Joint Commission)

- No verbal orders are to be given to a scribe.
- Name, title, date and timing of all entries should be clearly identifiable and distinguishable from the physician, LIP, or other staff member.
- Affirmation of the provider's presence during the time the encounter was recorded.
- Authentication by provider the information was reviewed for accuracy.
- Third-party payers may have specific guidelines for how the scribe documents and how the electronic signature must be signed.

Benefits of a Scribe

- Allows the provider to focus more on the patient, with the expectation that more physician face time with the patient hopefully will increase provider and patient satisfaction during the visit.
- Scribes often chart faster, so documentation completed is often available more quickly for review with improvements in overall documentation.
- Scribe documentation often is more detailed and comprehensive than a physician note as the Scribe is charting in "real time," capturing the details of the patient encounter in the provider's words.

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Your Privacy with the Cooperative of American Physicians, Inc.

The Cooperative of American Physicians, Inc. (CAP) promotes a range of products and services designed with the welfare of healthcare professionals in mind. From the professional liability protection services of the Mutual Protection Trust (MPT) and the CAPAssurance Risk Purchasing Group to the range of affiliated services provided through CAP's insurance agency, CAP's goal is to match health care providers with the best products and services — all tailored to fit their needs.

Information We Collect

When you join CAP, you provide us with non-public personal information. We collect and use that information to service your needs at CAP, MPT, and CAPAssurance. The non-public information we collect falls into two general categories:

- Information we receive from you on the application and other forms relating to CAP enrollment and professional liability coverage through MPT and CAPAssurance; and

- Information about your transactions with CAP, MPT, CAPAssurance, the CAP Physicians Insurance Agency, and CAP's affiliated service providers, including the Cooperative of American Physicians Insurance Company, Inc.

Website Operation

Information collected as a result of your visiting our website is handled in a secure manner and is used only for the following purposes:

Providing certain information only available to CAP members and participants. Some areas provide newsletters, articles, and applicant lists intended only for our members and participants. Therefore, we do request information verifying your CAP status before you are allowed access to those areas.

Security of your information. The website provides you with the ability to get information relating to your CAP status. Again, the information we collect is used only to verify that you are the one seeking such access.

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Enhancing your navigation throughout our website. Some information may be stored on your personal computer in the form of "cookies" or maintained temporarily on our web server to enable our web server to "remember" information as you move about the website. This is done to enhance your experience of the website.

Providing information that enables us to serve you better. We do collect statistical information on web page visits and identify individuals who requested information about their membership. The intent of this information gathering is

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to help us determine which parts of the website are most used and which parts can be improved, and how CAP can best serve its physicians.

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Information We Share

We want you to feel secure about the information you give to CAP. For this reason, we share with CAP's own insurance agency only contact information such as name, address, phone and fax numbers, medical specialty, plus your age. This information is not shared outside of CAP except that information regarding physicians' date of birth is shared with the outside insurance company that provides Group Term Life and Disability coverage to CAP physicians.

If you contact CAP's Human Resource Hotline, we may gather basic facts about your question. If we cannot answer your question, we may give your contact information for an outside law firm to assist you.

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- Receive notices regarding political activities affecting the medical professional liability industry and solicitations for contributions to CAP's political action committees

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Case of the Month

by Gordon Ownby

Put the Patient in the Information Loop

An abnormal test result typically sets in motion a number of follow-up actions by a patient's treaters. While many of those actions will depend on the particular situation, one of them should be a constant: Telling the patient.

A 51-year-old woman visited Dr. GS, a general surgeon, on a referral after an abnormal mammogram. The patient reported that her mother had a lumpectomy for breast cancer at age 65 and other family members experienced leukemia and bone, colon, and lung cancer. Dr. GS viewed the recent screening and diagnostic mammograms and noted marked density in both breasts with a particular 3 cm density on the lower right breast. An in-office ultrasound revealed a large dilated duct in the same area as the 3 cm density as well as multiple images consistent with cystic lesions. Dr. GS ordered an MRI and a colonoscopy and provided the patient with education and a care plan.

The patient returned three days later with a fever and right breast pain with streaking and redness. Dr. GS noted a swollen right breast with blotchy erythema and a hardened quadrant from 6-9 o'clock. Dr. GS' working diagnosis was mastitis. Dr. GS started the patient on Keflex and dicloxacillin. The patient returned three days later, feeling better. Another ultrasound showed increased fluid collection. Dr. GS recommended the patient return in three to four days, at which time they would consider the previously recommended MRI.

When the patient returned two weeks later, Dr. GS' nurse practitioner noted quadrants of mass-like hardening of the right breast and instructed the patient to now have her MRI, as the mastitis had improved.

The radiologist noted the MRI showed "multiple concerning lobulated enhancing masses localized in the lower inner quadrant . . . suspicious . . . directed ultrasound of area is needed. Ultrasound guided biopsy will be needed if lesions are identifiable. If not, MRI-guided biopsy will be recommended." The radiology office sent the report to Dr. GS, but only told the patient of the need for follow-up studies.

Several days later, Dr. GS' physician assistant sent an internal office memo to the front office staff asking if the patient had yet had the recommended biopsy. The front office told the PA that according to the radiology facility's portal, the patient had an appointment for an ultrasound coming up. On the day after that scheduled (but failed) appointment, Dr. GS' physician assistant initialed the original MRI report as read. No follow-up was scheduled. The radiology facility did not advise Dr. GS' office of the failed appointment.

Approximately 30 months later, the patient had a new screening mammogram that revealed a new mass. An MRI and biopsy confirmed a malignancy in the right breast. The patient returned to Dr. GS, who noted a large palpable mass on the right breast but no enlargement in the nearby lymph nodes. Dr. GS recommended a mastectomy and ordered a PET scan to rule out metastasis. After the scan came back as negative, Dr. GS discussed several treatment options and ultimately scheduled the patient for a bilateral mastectomy. Dissection during the procedure found three positive lymph nodes out of 34.

Postoperatively, the patient complained of arm numbness, lymphedema, and decreased mobility in her arm. She had to stop chemotherapy because of severe side effects but was able to undergo external beam radiation therapy. The patient's suit against Dr. GS for medical negligence was resolved informally prior to a trial.

Dr. GS' office's attempt to track the patient's pursuit of the recommended biopsy was likely handicapped by the patient's ignorance of the matter's urgency. The best "tickler" trails will be those that include telling a patient of an abnormal finding and explaining why further care is needed.

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