



X-Raying the Practice: Data Drive Higher Quality Outcomes

Urologist and CEO Dr. Edward Cohen is leveraging analytics to transform his practice.

"The new payer paradigm – the need to deliver higher quality at lower costs to get paid by Medicare – means there's a real need to change. Everybody's trying to figure out, 'how do we do this?'," says Dr. Edward Cohen.

For Dr. Cohen, the answer was clear. "To improve quality, you need to pick a metric, measure it, and

figure out how to change," he points out. He needed to use data to see inside his practice, especially since it has grown so successfully.

"Across the country, urologists have been forming larger groups," Dr. Cohen explains. "It gives you more control of patient care, which patients really want. Five years ago, we brought nine separate practices

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Cooperative of American Physicians, Inc. and Mutual Protection Trust

Notice of Joint Meeting of Members, July 28, 2016

A regular annual meeting of members of the Cooperative of American Physicians, Inc. (CAP), a non-stock membership cooperative corporation, and the members of the Mutual Protection Trust (MPT), an unincorporated interindemnity arrangement, will be held at:

333 S. Hope St., 8th Floor, Los Angeles, CA 90071
at 8:00 a.m. on July 28, 2016

to transact such business as may properly come before the meeting or any adjournment thereof.

The business day prior to the mailing of this notice shall operate as the record date for the determination of those members entitled to notice of the meeting. The Boards will present no items on the agenda for membership vote.

Paul R. Weber MD, PhD

Paul R. Weber, MD, PhD
Secretary of the CAP Board of Directors

Andrew Sew Hoy MD

Andrew Sew Hoy, MD
Secretary of the MPT Board of Trustees

together and I became CEO of Genesis Healthcare Partners. Today, we have 28 doctors, 200 employees, a pathology lab, a radiation group, an imaging center, and an advanced prostate cancer and research division. We even added a gastroenterologist group."

But Dr. Cohen wanted to know if owning so many service companies would tempt doctors to order more tests and procedures than are needed.

"I wanted us to be totally above board, so I named Dr. Franklin D. Gaylis to be our quality director. He tracked our metrics for every single doctor in our practice, and a year later the data showed we had been practicing appropriately," he explains.

Having those analytical skills was immediately useful. In 2012, the U.S. Preventive Services Task Force (USPSTF) recommended against prostate-specific antigen (PSA)-based screening for prostate cancer. "We respected the recommendation, but we couldn't ignore the fact that medicine had decreased death by prostate cancer by 25 percent. For us, the real question wasn't whether to use the test or not, but how could we better utilize it?

"That question led us to partner with Chris Kane at the University of California, San Diego School of Medicine to develop an Active Surveillance Protocol for prostate cancer. Rather than treating patients on day one, we use data to track their progress and see how we can improve outcomes within that group. We started sharing the data on how each doctor was performing: Here is where you are; here is where our group is; and here is where we are compared with the rest of the doctors across the country. Over time, doctors came to really value the feedback and it drove real improvements. We were excited, so we said 'what's next?'," Dr. Cohen says.

"We decided to reduce infections in prostate biopsies. We created 'time out' policies that ensure that before a biopsy is done, doctors can make sure they have the right patient, the right preparation, the right

antibiotics. It's another quality parameter we can measure, report on, and use to drive positive change," he states. "You have to measure what each doctor is doing over time. We don't **really** know how we're really performing unless we measure over time. That's the whole goal of quality: get the data and see what's really happening," Dr. Cohen emphasizes.

"We recently hired a graduate student who found a smart way to extract data from data tables from our EMR records to get more insight. For example, the drug Provenge can extend the lives of patients with castration-resistant prostate cancer, but it can only be used in a narrow time frame. Now, if we see that a patient's PSA doubling time is less than nine months, we can automatically alert our doctors that the patient might be ready for a bone scan to determine if Provenge should be prescribed. That would be impossible to do without our data."

Dr. Cohen's dedication to quality is matched only by his dedication to his family. He is devoted to his wife and his four sons, aged 19 to 26. On the weekends, you might find him skiing, playing golf, or taking long walks on the beach with his wife; or maybe on an airplane to New York, San Francisco, Seattle, or Colorado to visit one of his sons.

Dr. Cohen is proud of the progress Genesis has made. "It's very exciting leading the group, and I still do clinical work. My goal is to continue to protect the independent practice of medicine," he says. "The entrepreneurial spirit of independent doctors, their sense that 'I can make good things happen' is what provides some of the best healthcare in the country."✈

DR. COHEN AT-A-GLANCE

Medical Specialty: Urology

Practice Location: La Jolla and Encinitas, CA

Years in Practice: 26

CAP Member Since: 2003

Save the Date for CAP's Free Webinar

Concussion Management

The Physician's Risk Reduction Playbook

Thursday, July 28, 2016 | 2:00 p.m. to 3:00 p.m.

For more information, please visit www.CAPphysicians.com/cm

CHRIS GIZA, MD

Professor of Pediatric Neurology and Neurosurgery
at the David Geffen School of Medicine and Mattel
Children's Hospital

CATHERINE MILLER, RN, JD

CAP Senior Risk Management and Patient
Safety Specialist

Facing Reimbursement or Retention Woes?

CAP Now Offers Smart Solutions to Serious Challenges

Problem solving. It is what physicians do every day, whether determining the best course of treatment for patients, or finding creative ways to keep up with the barrage of regulations and requirements constantly hurled at them.

As you strive to resolve the formidable issues inherent in running a medical practice, CAP is there to support you along the way. We have recently partnered with a number of highly regarded organizations to offer you innovative and cost-effective programs that extend beyond medical liability coverage: programs designed reduce the stress of dealing with mundane administrative tasks, like practice marketing, online reputation management, and billing and payment.

How can we help you with your biggest challenges?

"My practice is small and I don't have the time or resources to commit to marketing, let alone managing online review sites."

Solution:

Simplify your practice marketing with a low-cost, all-in-one solution: **PatientPop**. This smart technology ensures that patients can find you online, verify that you are professional and legitimate, and easily book



appointments. **PatientPop** also helps patients leave great reviews and generate word-of-mouth referrals online.

Benefits:

- A customized website that is both search engine optimized and mobile optimized and that enables patients to book appointments directly on your site.
- Dissemination of positive patient reviews across all review sites to enhance online reputation.
- Automated appointment reminders to reduce no-shows.
- Easy-to-track metrics that demonstrate your return on investment.

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"As the reimbursement model shifts from fee-for-service to value-based compensation, how can we proactively track performance data to ensure equitable and timely payment?"

Solution:

The **Patient Experience Survey Program (PESP)**.

This high-performance, cost-effective online survey platform quickly and precisely reports what patients think of you, your staff, and their overall appointment experience, so you can stay one step ahead of value-based compensation.

Benefits:

- Immediate patient feedback to expeditiously address issues and deliver a superior patient experience.
- Knowledge of where your practice is excelling and where performance can be improved.
- Objective, HIPAA-compliant data that may help in securing prompt and fair payment from public and private payers.

"My revenue is down. How do I increase the profitability and efficiency of my practice without compromising patient care?"

Solution:

Through our partnership with **athenahealth**, CAP members have easy access to an integrated practice management tool that provides real back-office support. Best of all, you can pick and choose solutions that complement your current office operations.

Benefits:

- Combine EHR, practice management, and care coordination into a single, powerful tool.
- Optimize revenue and stay better focused on patient care.
- Secure full payment faster; reduce administrative cost and drag.
- Improve the patient experience and get patients more fully engaged in their own care.
- Maximize clinical productivity by organizing the moment of care.

For more information about any of these dynamic new practice management solutions, contact our chief practice problem solver, Sean O'Brien, vice president, Membership Programs, at sobrien@CAPphysicians.com, or call 213-473-8740. Mr. O'Brien is well-versed in the features and benefits of these programs and is happy to walk you through them and refer you to the best contact. ➦

Case of the Month

by Gordon Ownby



Court Curbs Abuse of Elder Abuse Law

In a long-awaited decision, the California Supreme Court has firmly rejected a common practice of injecting allegations of elder abuse into disputes over office-based medical care.

In 2004, Elizabeth Cox saw a podiatrist at Pioneer Medical Group for a painful toenail infection. The podiatrist at the group recorded pulses that reflected impaired vascular flow in Ms. Cox's lower legs and sent a copy of his report to her regular family practitioner at Pioneer, Dr. FP. (As is normal for appellate cases, all facts used in the Supreme Court's decision derive from the plaintiff's allegations and are deemed admitted by the defendants only for the purpose of legal analysis.)

From 2007 to 2009, Ms. Cox's vascular symptoms in her legs worsened. Between numerous visits with her original podiatrist, Dr. FP, and a second podiatrist at Pioneer, her treaters found reduced or no pulse in her extremities, cellulitis, peripheral vascular disease, a chronic non-cubitus ulcer of the toes, and abnormal weight loss. Treatment included drainage, antibiotics, topical cream, foot soaks, and special shoes.

In March of 2009, Ms. Cox was admitted to the hospital with symptoms consistent with ischemia and gangrene and physicians unsuccessfully attempted a revascularization procedure. The next month, Ms. Cox underwent a below-knee right leg amputation and then had an above-knee procedure two months hence. In January 2010, Ms. Cox was hospitalized for blood poisoning and died several days later.

In addition to a lawsuit for medical malpractice against Pioneer and their mother's physicians, Ms. Cox's daughters filed a complaint for elder abuse, alleging that the defendants consciously failed to refer Ms. Cox to a vascular specialist. At the trial court level, the medical defendants successfully defeated the elder abuse allegation when the judge ruled that the plaintiffs had failed to allege anything more than "mere negligence," the "provision of inadequate care," and "incompetence."

The Court of Appeal reversed the trial court judge, but in *Winn v. Pioneer Medical Group, Inc.*, the California Supreme Court said the elder abuse allegations cannot apply in the medical setting at issue.

Under California's Elder Abuse and Dependent Adult Civil Protection Act, a plaintiff family member who can prove by "clear and convincing evidence" that a defendant is liable for physical abuse or neglect through "recklessness, oppression, fraud, or malice" may win attorney fees and additional damages for the pain and suffering experienced by the patient before death – money that is not available in a conventional medical malpractice award. The relevant statutory definition of "neglect" is "[t]he negligent failure of any person having the care and custody of an elder or a dependent adult to exercise that degree of care that a reasonable person in a like position would exercise."

In *Winn*, the Supreme Court focused on whether care provided in an outpatient setting satisfies the Elder Abuse Act's requirement that the individual be in the "care and custody" of the person accused. The unanimous Court found that it does not.

"[N]othing in the (Elder Abuse Act's) legislative history suggests that the Legislature intended the Act to apply whenever a doctor treats an elderly patient," the Court wrote. "Reading the Act in such a manner would radically transform medical malpractice liability relative to the existing scheme. No portion of the legislative history contains any indication that the Legislature's purpose was to effectuate such a transformation of medical malpractice liability," the Court found.

"What we conclude is that the Act does not apply unless the defendant health care provider had a substantial caretaking or custodial relationship, involving ongoing responsibility for one or more basic needs, with the elder patient." ➦

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



Identifying Human Trafficking Victims in a Healthcare Setting

by Dona Constantine, RN

According to California Attorney General Kamala D. Harris, "Human trafficking is the world's fastest growing criminal enterprise and is an estimated \$32 billion-a-year global industry. It is a form of modern day slavery that profits from the exploitation of our most vulnerable population."

Human trafficking victims are not just trafficked for sex. They also can be trafficked for labor and found in occupations such as, but not limited to, domestic servants, hotel maids, nail or massage salon and restaurant workers.

The United States is widely regarded as a destination country for human trafficking. The U.S. Department of State estimates that 14,500 to 17,500 of victims are trafficked into this country each year. California, with a significant immigrant population, is one of the top destinations for trafficking human beings. Los Angeles is one of the main trafficking hubs.

Although trafficked human beings can be difficult to recognize, many are treated by physicians and their staff. **All who work in healthcare are in a unique position to help identify victims.** A patient's behavior may be a clue, such as being fearful, not speaking for themselves, or being controlled by another who speaks for the patient. Bruises may be present that do not match the description of how the injury took place. There may be lack of a passport or other identifying papers. Even though some of these clues may signal other situations such as domestic violence or child abuse, it is important to become familiar with the "red flags" for identifying potential victims, which are found on a number of websites, most notably the following:

Immigration and Customs Enforcement - Blue Campaign - Human Trafficking 101 <https://www.dhs.gov/sites/default/files/publications/bc-inf-ht101-blue-campaign-human-trafficking-101.pdf>

(Harris, KD, 2012) The State of Human Trafficking in California, Attorney General California Department of Justice <http://oag.ca.gov/sites/all/files/agweb/pdfs/ht/human-trafficking-2012.pdf>

The U.S. Department of Health and Human Services Health Provider's Screening Tool for Victims of Human Trafficking http://www.acf.hhs.gov/sites/default/files/orr/screening_questions_to_assess_whether_a_person_is_a_trafficking_victim_0.pdf

Be cautious when assisting an identified trafficking victim, because the trafficker might threaten to or actually harm you, the victim, or their families. The following resources are available for either a healthcare provider to assist or for patients themselves to use in order to gain freedom:

California Model Poster available in English, Spanish, and Chinese to post in emergency department and urgent care facilities <http://www.govdocs.com/free-california-human-trafficking-poster-local-solution-to-global-problem/>

California Coalition to Abolish Slavery and Trafficking (CAST) 888-KEY-2-FRE(EDOM) or 888-539-2373 <http://www.castla.org/homepage>

National Human Trafficking Resource Center 888-373-7888 or 888-3737-888 <https://traffickingresourcecenter.org/sites/default/files/Healthcare%20Assessment%20-%20FINAL%20-%202016.16.pdf>

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Fighting Human Trafficking

In 2004 and 2005, the U.S. Department of Justice awarded grants to create six regional task forces in California to combat human trafficking. In 2009 and 2010, the California Emergency Management Agency used American Recovery and Reinvestment Act grant funds to supplement the original six task forces and establish three new regional task forces.

From mid-2010 to mid-2012, California's nine regional human trafficking task forces identified 1,277 victims, initiated 2,552 investigations, and arrested 1,798 individuals. As part of their work to combat human trafficking, the task forces also provide training to a variety of audiences on how to identify and respond to the crime. In the same two-year period, California's task forces provided training to 25,591 law enforcement personnel, prosecutors, victim service providers, and other first responders.

California's regional anti-human trafficking task forces employ a comprehensive, victim-centered approach, and are made up of law enforcement and local, state, and federal prosecutors, as well as other governmental leaders and nongovernmental organizations.

Task Forces and Lead Nongovernmental Organizations

- East Bay Human Trafficking Task Force; Oakland Police Department 510-238-3349
- Alameda County District Attorney's Office H.E.A.T. (Human Exploitation and Trafficking) Unit 510-208-4959
- Bay Area Women Against Rape, Oakland 510-430-1298 <http://bawar.org/>
- Fresno Coalition Against Human Trafficking; Fresno Police Department 559-621-5951

- Central Valley Against Human Trafficking, Fresno County Economic Opportunities Commission 559-263-1000 <http://fresnoeoc.org/>
- Marjaree Mason Center, Fresno 559-237-4706 <http://mmcenter.org>
- Los Angeles Metro Area Task Force on Human Trafficking: Coalition to Abolish Slavery and Trafficking (CAST), 213-365-1906 <http://castla.org> ➦

Dona Constantine is a senior risk management and patient safety specialist for the Cooperative of American Physicians. Questions or comments related to this article should be directed to dconstantine@CAPphysicians.com.



Post jobs for free on the CAP JOB BOARD

As an exclusive benefit of CAP membership, you are entitled to post physician job openings on the free CAP Job Board, exposing your practice to qualified physicians of all specialties. Once your 90-day listing expires, you can renew at no cost.

Visit jobs.CAPphysicians.com to get started!

Medicare Proposes Changes to Physician Payments

The Centers for Medicare and Medicaid Services (CMS) has unveiled a proposal that would carry out a major overhaul of its payments for physicians. The proposed rules, released on April 27, stem from a mandate included in last year's passage of the Medicare Access and CHIP Reauthorization Act (MACRA), federal legislation that repealed the Medicare sustainable growth rate formula (SGR).

MACRA puts in place a new reimbursement framework called the Quality Payment Program (QPP). The QPP consists of two tracks: the Merit-based Incentive Payment System (MIPS) and the Advanced Alternative Payment Model (APM). All eligible clinicians will report through MIPS during the first year of the program – calendar year 2017. After the collection of the first year's data, CMS will determine which providers meet the requirements for the APM track. Those physicians will have the option to choose between the MIPS and APM tracks annually.

Under the proposed rule, eligible clinicians include physicians, physician assistants, nurse practitioners, clinical nurse practitioners, certified nurse anesthetists, and groups that include such physicians. Exempted will be Medicare newly enrolled (first year) clinicians and clinicians below the low-volume threshold. MIPS will not apply to hospitals or facilities and clinicians providing services in Rural Health Clinics, and Federally Qualified Health Clinics will be required to participate in MIPS if they provide services under the Physicians Fee Schedule.

Though the performance measurement period begins in 2017, the new payment system, if approved as proposed, takes effect in 2019. MIPS will combine the existing Physicians Quality Reporting System (PQRS), the Valued-based Modifier, and the Electronic Health Records Incentive (Meaningful Use) programs. The consolidation of programs aims to streamline the process that will measure the quality and efficiency of care delivered.

Starting January 1, 2017, and running through December 31, 2017, the MIPS reporting path will



consist of physicians being evaluated and scored in four performance categories:

- **Quality** (50 percent of total score in 2017). Clinicians will choose six measures, from a list of 200, to report based on those that best reflect their practice and outcome measurements.
- **Advance Care Information** (25 percent of total score in 2017). Clinicians will choose to report on customizable measures (which will be reduced from 18 to 11) that reflect the use technology in their day-to-day practice with an emphasis on interoperability and information exchange.
- **Clinical Practice Improvement Activities** (15 percent of total score in 2017). This category would reward clinical practice improvements that focus on areas such as care coordination, beneficiary engagement, and patient safety. Clinicians will be able to select from more than 90 options to best match their practice's goals.
- **Cost** (10 percent of total score in 2017). In this last category, a score will be based on Medicare claims, meaning no reporting requirements for clinicians. The category will use 40 episode-specific measures to account for differences among specialties.

The Advanced APM path is for clinicians who meet certain thresholds on patient contact or who receive

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enough of their payments through Advanced APM models, such as the Medicare Shared Savings Program (Tracks 2 or 3), Comprehensive Primary Care Plus, the Comprehensive End Stage Renal Disease (ESRD) care model, and the Next Generation Accountable Care Organization (ACO) model. In general, these models require participants to bear a certain amount of financial risk, base payments on quality measures similar to those under MIPS, and require use of certified electronic health record technology. Medical home models also qualify as Advance APMs regardless of whether they meet the financial risk requirement. After 2017, CMS will determine which MIPS clinicians can further qualify to participate in an

Advance APM. These physicians will be exempt from MIPS, but may nonetheless choose to operate under the MIPS model.

The deadline to submit a comment on the proposed regulations is June 27, 2016. CMS must release the final regulations by November 1, 2016.

The following offers a detailed summary of MIPS:

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/NPRM-QPP-Fact-Sheet.pdf> ➦

Have You Done Your Annual Insurance Checkup?

Sometimes, we are so busy with pressing clinical and operational matters that we forget to take the time to review our insurance portfolio and make sure we are covered properly. CAP knows how difficult it can be for our members to meet all the challenges they face, which is why we created CAP Physicians Insurance Agency, Inc., a wholly owned CAP subsidiary. Through this agency, CAP members have their very own consultants available to help them get adequately protected on all fronts, not just their medical malpractice coverage.

Just like doing a physical checkup, it is a good idea to review your medical practice and your personal life each year – especially if there have been changes that may increase your risk. Perhaps you have grown or changed the nature of your practice, hired additional staff, purchased new equipment, or opened or moved to a new location. On the personal side, you may have a new addition to the family, a new teenage driver, a new vacation home, or a new boat or other hobby item. Whatever the change, it may increase your exposure both professionally and personally.

The licensed, trained professional insurance agents of CAP Physicians Insurance Agency, Inc. will walk you through the risk exposures and insurance solutions and do a checkup on your current coverage, as well as provide you with comparative, competitive quotes at no cost to you. CAP Agency is like having your own personal insurance consultant. The agency's insurance carriers, many of which are rated A+ by A.M. Best Company, know the medical community and understand physicians and their practice needs. CAP Agency has access to the best insurance programs to protect our member physicians.

Let us help you with your checkup. Contact CAP Agency to quickly get quotes and personalized consulting at 800-819-0061 or at CAPAgency@CAPphysicians.com.

To further assist you in obtaining proper coverage, be on the lookout for *The Physician's Action Guide to Business Insurance*, coming soon from CAP and the CAP Agency. ➦

June 2016



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Enclosure: Free Online CME Courses Exclusively for CAP Members

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We welcome your comments! Please submit to communications@CAPphysicians.com

*The information in this publication should not be considered legal or medical advice applicable to a specific situation.
Legal guidance for individual matters should be obtained from a retained attorney.*

June 2016



CAP/Medical Interactive Online CME Program

Do You Need a Few CME Credits? Get Them Free!

CAP's Risk Management and Patient Safety Department has partnered with Medical Interactive to offer our members an extensive selection of free online CME courses. This program is available to all CAP physicians.

Medical Interactive offers more than 100 courses for 28 specialties. The courses emphasize patient safety problems and risk management solutions. Course speakers and authors include national experts, physicians in practice, and professional medical writers. The course offerings reflect educational needs based on assessing claims data, peer-reviewed literature, the latest professional practice guidelines, and new regulatory measures.

Highlights:

- CME courses approved for Maintenance of Certification (PART II)
- NCC EFM Certification review prep course
- Diagnosis University: Largest collection of diagnosis-related CME
- MI Perinatal University: Obstetrical Risk Management and Patient Safety CME/CNE

The collection of courses has been accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide CME.

A sample of the course offerings is listed on the reverse side of this enclosure.

New, simple, easy sign-up process

How to access these courses:

For free access to more than 100 courses, please visit www.CAPphysicians.com/cme. First-time users will need to register for a free account.

Members who have accessed the online CME courses through our "Members Only" site may continue to do so there.



COOPERATIVE OF
AMERICAN PHYSICIANS

Online Educational Activities

Following is a partial list of course offerings

Anesthesiology

Emerging Risks in Anesthesiology

Cardiology

Risks and Claims in Cardiology

Aortic Disease I: Diagnosing Aneurysm

Aortic Disease II: Diagnosing Dissection

New Options in Anticoagulant Therapy

Cardiovascular Thoracic Surgery

Risk and Claims in Cardiovascular

Thoracic Surgery

Dermatology

Risk and Claims in Dermatology: Melanoma

Emergency Medicine

Risk and Claims in Emergency Medicine

Aortic Disease I: Diagnosing Aneurysm

Aortic Disease II: Diagnosing Dissection

EMTALA—What Physicians Need to Know

Diagnostic Error and Dizziness

Diagnostic Error and Stroke

Stroke Treatment in the ED:

2013 TPA Guidelines

Gastroenterology

GI Claims I: The Connection Between

Complications and Consent

GI Claims II: The Emerging Risk of

Deep Sedation

General Surgery

General Surgery Claims and Case Study

Geriatrics

Nursing Home Patients: Reducing the

Risk in Long-Term Care

Managing Anticoagulant Therapy, Warfarin

New Options in Anticoagulant Therapy

Polypharmacy and the Elderly

Internal Medicine, Family Practice, General Practice

Aortic Disease I: Diagnosing Aneurysm

Aortic Disease II: Diagnosing Dissection

Prof. Liability Risks in Family

and General Practice

Prescribing Controlled Substances:

Reducing the Risk

Nursing Home Patients: Reducing the

Risk in Long-Term Care

Managing Anticoagulant Therapy, Warfarin

New Options in Anticoagulant Therapy

Diagnostic Error and Claims

Understanding and Reducing Diagnostic Error

Diagnostic Error and Dizziness

Diagnostic Error and Stroke

Diagnostic Error: “Just a Sore Throat”

Diagnostic Error in Heart Failure

Diagnostic Error in Community

Acquired Pneumonia

Diagnostic Error in Ileus vs. Obstruction

Neurology

Diagnostic Error and Dizziness

Diagnostic Error and Stroke

Nursing Activities

Stroke Treatment in the ED:

2013 TPA Guidelines

Obstetrics-Gynecology

Reducing Elective Deliveries Before

39 Weeks’ Gestation

Operative Vaginal Delivery and Birth Trauma

Ophthalmology

Ophthalmology Closed Claims Analysis

Risks Issues in General Ophthalmologist:

Retinal Tears

Orthopedics

VTE Prophylaxis in Joint Replacement

2013 AAOS Guidelines OA Knee: An RM Review

Otolaryngology

New Developments in Sinusitis

for Otolaryngologists

Pediatrics

Claims and Risk in Pediatrics

CT Radiation Dosing

Obstructive Sleep Apnea for All Specialties

Diagnostic Error: “Just a Sore Throat”

Plastic Surgery

Risk and Claims in Plastic Surgery I:

An Overview

Risk and Claims in Plastic Surgery II:

Selected Issues

Pulmonology

Risk and Claims in Pulmonology:

Lung Cancer Screening

Radiology

Diagnostic Error in Radiology

Nursing

Incident Reporting – The Clear Picture

EMTALA: Regulation and Best Practices

for Nurses

Reducing Elective Deliveries Before

39 Weeks: What Nurses Need to Know

Wound Care Assessment

Battling Clinical Alarm Fatigue

Improving Patient Trust Through Disclosure

OSHA’s New Hazard Communication

Standard: Preparing Hospitals for

the 2013 Deadline

Polypharmacy in the Elderly:

What Nurses Should Know About

Managing Multiple Medications in

Older Adults

Check back monthly.

New courses are added frequently.