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OCTOBER 2024

Case of the Month

Combating the Elusive Diagnosis of Appendicitis

Three Case Studies

by Dona Constantine, RN, BS

"Appendicitis is one of the most common surgical emergencies in the United States. However, the diagnosis of appendicitis is missed in 3.8%-15.0% of children and 5.9%-23.5% of adults during emergency department (ED) visits. Appendicitis is the second most common condition among pediatric patients and the third most common condition cited in adult malpractice insurance claims."[1]

CASE STUDY #1 10-YEAR-OLD ROBBY

"Robby," a 10-year-old male presented to the emergency room with poor appetite for three days, vomiting, stomach pain, side pain, nausea, and diarrhea. He was seen by a physician assistant (PA), who did a Jump Test for appendicitis. The test was negative for rebound pain, although this was not documented.

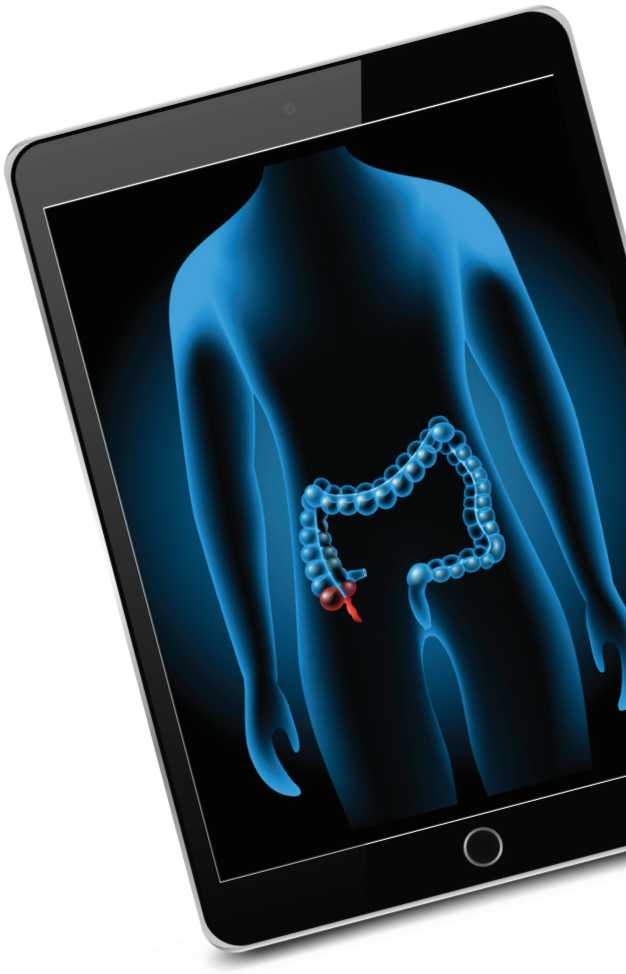
The care plan included antibiotics, labs, Zofran for nausea, Tylenol for pain, and instructions to return to urgent care if his condition persisted or worsened.

Three days later, Robby returned to urgent care and was seen by a pediatrician, Dr. A. Robby continued to have abdominal pain, persistent fever and diarrhea, and a newly increased white blood count (WBC). Dr. A. diagnosed Robby with infectious diarrhea and prescribed antibiotics. Unfortunately, Robby ultimately developed a perforated appendix with peritoneal abscess and sepsis, requiring surgery and a prolonged hospitalization with intubation and multiple blood transfusions. He suffered septic shock and ileus. Luckily, Robby survived, but not without significant clinical decline, suffering, and substantial medical interventions.

The family filed a lawsuit, and the case was settled.

CASE STUDY #2 75-YEAR-OLD THOMAS

"Thomas," a 75-year-old male presented to his primary care physician, Dr. D., complaining of abdominal pain. Dr. D. diagnosed him with dehydration secondary to gastroenteritis. Three days later, Thomas was transported to the ED with severe abdominal pain and diarrhea with bleeding. Lab results revealed a WBC of 16,000 with left shift.



continued on page 3

Continued from page 2

The ED physician ordered an abdominal CT for non-specific abdominal pain. Radiologist #1 identified a distended gallbladder, 4.5 cm abdominal aortic aneurysm (AAA) and adynamic ileus. Thomas was admitted to the hospital by Dr. O. Diagnoses were gastroenteritis, acute renal insufficiency secondary to gastroenteritis, hypokalemia, and AAA. Orders were given for overnight Phenergan and IV fluids with a plan to reevaluate the patient the following day. On his first night in the hospital, the night nurse noted that Thomas' abdomen was firm upon palpation with decreased bowel sounds. However, the nurse did not notify the physician of these findings.

Thomas continued to complain of abdominal pain and serial plain view X-ray images were ordered. Radiologist #2 read the films as suspicious for a mechanical small bowel obstruction and recommended a surgical consult. This recommendation was not acted on until two days later when Surgeon A consulted the patient and suggested conservative care, with no surgical intervention. The following day, Thomas' condition deteriorated, so Surgeon A performed an exploratory laparotomy which revealed a very large peritoneal abscess, purulent peritonitis, and perforated appendix.

Thomas was subsequently followed by multiple specialists including nephrology, pulmonology, and neurology. Unfortunately, Thomas never recovered from surgery and expired nine days post admission due to metabolic encephalopathy secondary to sepsis. Following the patient's death, the initial CT scan was reread—findings consistent with appendicitis were evident.

Thomas' family filed a lawsuit, and the case was settled prior to trial.

CASE STUDY #3 A Family Affair

Appendicitis is the most common cause of sudden (acute) belly pain that requires surgery. It mostly happens in teens and young adults in their 20s, but it can happen at any age. Having a family history of appendicitis may raise your risk, especially if you are a male.[2]

"Bryan," a 16-year-old male, was one of three sons in his family of five. Both of his brothers had previously had an appendectomy. One night, Bryan developed severe abdominal pain that kept him up all night. When he arrived at the ED for an evaluation, he looked "good" and felt better. During the history intake, Bryan told the ED physician about his two brothers' prior appendectomies and shared that his father and both of his grandfathers all had appendicitis. Upon hearing this, the ED physician said, "Say no more. I'm ordering a CT, and I expect you will be having surgery today." Indeed, Bryan was diagnosed with appendicitis and an appendectomy was performed that day.

Interestingly, while Bryan and his family all shared the diagnosis of appendicitis, they each had a different presentation. Bryan's oldest brother was affected with intense pain intermittently for a few months, thinking that it was a bad case of constipation. Bryan's middle brother presented to an urgent care center with such intense pain that his eyes rolled back in his head and his blood pressure dropped dangerously low, requiring paramedic transport to the hospital.

Fortunately, in Bryan's case, the ED physician was aware of his significant family history and ordered a CT scan rather than an X-ray. According to one study, patients with a potentially missed diagnosis of appendicitis were more likely to be examined using only abdominal radiography during the initial ED visit.[3]

Risk Management Strategies

In light of the cases above, providers should consider these risk management strategies when presented with patients complaining of abdominal pain to help keep patients safe and minimize risk:

Gender Considerations

- Perform a detailed history when evaluating males with abdominal pain. Include questions as to whether other male family members have had appendectomies.
- While the featured cases represent male patients,

continued on page 4

Continued from page 3

it is important to note that a missed diagnosis of appendicitis was more likely to occur in women patients with comorbidities, and patients who experienced abdominal pain accompanied by constipation.[3]

• With pregnant women specifically, providers must maintain a high index of suspicion for appendicitis, as the symptoms can mimic common pregnancy-related discomforts, and the obstetrician should also be involved in the medical evaluation. Similarly, an elevated WBC is not reliable in pregnant women due to normal physiological changes in pregnancy.[4]

Documentation

Document intake information and assessments carefully. In the first case, the patient and parents reported that the pain was in the right lower quadrant, not the right upper quadrant as was documented. This created a credibility issue between the family and providers. Additionally, the Jump Test and findings were not included in the medical record. Documentation of this test and the corresponding findings may have released the PA from the claim.

Follow-up Visits

Proactively schedule follow-up visits rather than leaving it up to the patient or guardian to determine if a return visit is indicated. Schedule a follow-up visit to reevaluate the patient and the probability of appendicitis.

Independent Clinical Evaluations

Cognitive biases are hypothesized to influence physician decision-making.[5] One such cognitive bias is anchoring bias, under which physicians focus on a single—often initial—piece of information when formulating a diagnosis without sufficiently adjusting to later information.[5] In the second case, several physicians relied on the original misread CT scan written report without reviewing the actual CT scan images. Had other physicians independently reviewed the CT images, it may have accelerated the diagnosis of appendicitis and surgical intervention, and helped to save the patient's life.

Effective Communication

Timely communication of significant findings, i.e., change in the patient's condition (firm abdomen and diminished bowel sounds) or abnormal test results with recommendation for surgical consult may not have changed the outcome in the second case due to anchoring bias. However, in other cases, effective communication of this information may alert a physician that a more serious issue is developing, and a surgical consult needs to be completed sooner.

Because symptoms of appendicitis can be diverse, the risk management strategies detailed above become increasingly important for avoiding misdiagnosis and improving patient outcomes.

Dona Constantine, RN, BS, is a Senior Risk Management and Patient Safety Specialist. Questions or comments related to this article should be directed to DConstantine@CAPphysicians.com.

Sources

[1]Mahajan P., Basu T., Pai CW., Singh H., Petersen N., Bellolio MF., Gadepalli SK., Kamdar NS., Factors Associated With Potentially Missed Diagnosis of Appendicitis in the Emergency Department, National Library of Medicine, JAMA Network Open, 2020 Mar 9, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7063499/

[2]Appendicitis, Health, Johns Hopkins Medicine, The Johns Hopkins University, The Johns Hopkins Hospital, and Johns Hopkins Health System, accessed September 5, 2024; https://www.hopkinsmedicine.org/health/conditions-and-diseases/appendicitis#

[3]Mahajan P., Basu T., Pai CW., Singh H., Petersen N., Bellolio MF., Gadepalli SK., Kamdar NS., Factors Associated With Potentially Missed Diagnosis of Appendicitis in the Emergency Department, National Library of Medicine, JAMA Network Open, 2020 Mar 9, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7063499/

[4]Weinstock, M. B., & Longstreth, R. (2017). *Bounce backs! Emergency department cases: ED returns*. Commentary by G. L. Henry. Anadem Publishing, p. 416.

[5]Ly DP, Shekelle PG, Song Z., Evidence for Anchoring Bias During Physician Decision-Making, National Library of Medicine, JAMA Intern Med,. 2023 Aug 1, https://pubmed.ncbi.nlm.nih.gov/37358843/

RISK MANAGEMENT
AND
PATIENT SAFETY NEWS

Caution Ahead: The Potential Perils of Treating Doctors, Friends and Family Members, and "VIPs"

by Yvette Ervin, JD

Physicians are highly regarded for their skill, professionalism, and dedication to helping others. Many times, physicians become the "go-to" person for families, friends, and colleagues in need of medical advice or attention. Yet the desire—and pressure—to go above and beyond for those closest to you and/or for select patients can be difficult to navigate and lead to blurred boundaries, clouded judgment, and exceptions to routine protocols, which can put you and your patients at risk for suboptimal outcomes.

DOCTORS AS PATIENTS

Treating another doctor comes with a unique set of challenges and considerations. Knowing that your patient is a fellow physician can affect your behavior and communication, and impact care.[1] In a 2022 Medscape poll, more than half of the physicians who responded admitted to treating their physician-patients differently from other patients.[2]

Doctors frequently assume that their physician-patients know more about their medical condition, treatment, diagnosis, or upcoming procedure than they do.[1] This kind of assumption can lead to limited information sharing, minimal explanations about conditions, and presumptions that the patient is adhering to treatment plans and is forthcoming with relevant details.[1]

Doctors may also assume that their physician-patients expect them to spend more time or provide informal or off-the-record consultations. It is also a common assumption that physician-patients assess their doctor's expertise. This assumption can create anxiety or a tendency to second-guess recommendations, and at times, lead the treating doctor to defer to the physician-patient to direct their care.[1] It may also be more challenging for both the physician and patient to ask questions or to correct misinformation for fear of contradicting a peer.

FRIENDS AND FAMILY MEMBERS

While there are no laws prohibiting a physician from treating a family member or close friend, the Medical Board of California discourages this practice.[3]

At first glance, refusing to treat family members seems like a simple line to draw, but in fact, treating family and close friends is a widespread practice among physicians. Prescriptions of antibiotics, antihistamines, and contraceptives are among the most common treatments.[4] In a 2010 survey, an overwhelming number of plastic surgeons indicated that they had performed a procedure on a family member, with 88% stating that they would operate on a family member.[5] Even physicians who have made it a point not to treat family members may find themselves in difficult situations. Scenarios such as a family vacation when their six-month-old nephew presents with symptoms of an ear infection or a dinner party where their brother-in-law discloses symptoms of recent onset of headaches and blurry vision are good examples of how the physician may be positioned to help, but should they?

continued on page 6

Continued from page 5

Because of the inherent intimacy with family members and close friends, a physician's professional objectivity may be disrupted by their emotional involvement with the patient.[6] Their personal sentiments on treatments, interventions, and recommendations could result in potentially dangerous outcomes[5] and make it difficult for family member patients to get second opinions or ask questions, depending on the family dynamic.

As a result, ethical guidelines indicate that physicians should not treat family members and/or non-patients except in cases of emergency or minor short-term issues.[4]

"VIP" PATIENTS

Despite being met with the usual discontent by staff and providers, the very important patient (VIP) remains an existing patient classification in many healthcare institutions. These patients are often celebrities, CEOs, local government officials, or otherwise well-connected persons in their communities.[7] Perks for these patients not only include comfort enhancements, such as superior patient menus, hospital suites, or a personal concierge, but also preferred clinical services, such as easy access to the most sought-after providers, and expedited care. Yet for physicians, the pressures that sometimes accompany treating VIPs and the expectations associated with better service and clinical outcomes can create the opposite effect and negatively impact care, a scenario nicknamed "VIP syndrome."[7]

One significant contributor to VIP Syndrome is the tendency to steer away from established protocols to expedite services for the VIP patient. This can be in the form of eliminating routine preliminary tests, creating alternative schedules, or rushing through standard practices and protocols.[8] These changes are often made with good intentions to minimize a patient's discomfort or inconvenience, but can result in staffing issues, clinical gaps, and staff resentment towards the patient. VIP patients often have a hospital administrator overseeing their experience. This additional spotlight can lead to increased anxiety for the treating physicians and staff, and decreased privacy for the patient because of unwanted attention or visits from hospital CEOs or department chiefs.

Best Practices

In many ways, the same best practices and risk-reducing strategies that you would employ when treating all patients come into play when treating different classifications of patients. Providers should have an awareness of the complexities that can accompany treating certain patients, and recognize when the typical issues or pressures of these relationships are present.

Person-Centered Care

Hippocrates said, "It is more important to know what sort of person has a disease than to know what sort of disease a person has."[9] The idea of person-centered care is tailoring the care to meet an individual's needs. It is important to acknowledge the patient's individuality, lifestyle, experience, and care goals. For a physician-patient, acknowledge their background without assumptions, so you avoid the trap of limiting communication or information. Instead, engage them in discussions about their care and be open to their input or suggestions. Your VIP patient may have specific concerns regarding how treatment may impact their lifestyle or schedule, and in turn, you can try and tailor the care plan to help meet their needs and preferences when appropriate.

continued on page 7

Continued from page 6

Clear Communication and Expectations

Whether treating a VIP, friends or family, or a physician-patient, it is important to set clear boundaries. With each of these types of patients, there may be the perception—whether accurate or not—that they require more time or access to you. Set boundaries from the outset as to your hours, expected response time, and the appropriate contacts for scheduling visits. You should not provide your personal cell phone number or feel the need to respond to non-urgent issues after-hours. Let your patient know that they need to schedule a visit to discuss their care. Efforts to initiate care discussions at a family barbecue or a physician-patient request for a personal hallway consult should be redirected to the appropriate channels.

Adhere to the Fundamentals of Excellent Care and Know the Legal Implications

Dr. Benjamin Ansell, UCLA professor at the David Geffen School of Medicine stated, "The fundamentals of patient care need to be the same, regardless of wealth, influence or celebrity."[10] In the scenarios we have discussed, there is a tendency to circumvent protocols in the pursuit to increase efficiencies and accessibility, or meet patient demands and preferences. Providers may even find themselves in the "backseat." Instead of a collaborative shared decision-making approach, the patient is driving the care. As much as providers should respect patient values and knowledge, roles should be clarified, with you as the clinical expert, providing your professional guidance and recommendations. Legally, you are the one held accountable to the standards of care in your field of medicine. Regardless of a patient's insistence, you should not entertain treatments that you would not recommend. You will have to be able to provide clinical justification for your care decisions.

With friends and colleagues, you need to know when a patient-physician relationship has been established. Once you begin treatment, even if for a short-term issue, you are accountable for the interaction, the documentation of it, and the consequences.

Being aware of the dynamics of these patient classifications and staying grounded in the patient-physician relationship are key to navigating the challenges that you may face. Remain faithful to your clinical expertise and judgement, and you will be equipped to successfully provide quality care to any patient.

Yvette Ervin, JD, is a Senior Risk Management and Patient Safety Specialist. Questions or comments related to this article should be directed to YErvin@CAPphysicians.com.

References

[1]Noriega C., Three things you need to know when your patient is a doctor, Medical News Today, Healthline Media UK Ltd., 2017 Jul 12, https://www.medicalnewstoday.com/articles/318033#How-assumptions-can-affectcare

[2]Lehmann C., Docs Treating Other Doctors: What Can Go Wrong?, Medscape, WebMD LLC, 2022 Dec 16, https://www.medscape.com/viewarticle/985690?form=fpf

[3]Frequently Asked Questions, Complaint: General Office Practices/Protocols, Medical Board of California, CA.Gov, Accessed 2024 Aug 1, https://www.mbc.ca.gov/FAQs/

[4]Latessa R., MD, Ray L., MD, Should You Treat Yourself, Family or Friends?, FPM, AAFP, 2005 Mar, https://www.aafp.org/pubs/fpm/issues/2005/0300/p41.html

[5]Nesvig K., A Plastic Surgeon Operated On His Wife. Now He's Being Arrested For Manslaughter, Allure, Conde Nast, 2024 Jun 21, https://www.allure.com/story/florida-plastic-surgeon-arrested-for-manslaughter-wife

[6]AMA Council on Ethical and Judicial Affairs, AMA Journal of Ethics, American Medical Association, 2012 May, https://journalofethics.ama-assn.org/article/ama-code-medical-ethics-opinion-physicians-treating-family-members/2012-05

[7]Rockwell H., Keller EJ., Tadros A., and Newton I., VIP Patients in Interventional Radiology: Do Some Patients Deserve 'Better' Care?, National Library of Medicine, ncbi.nlm.nih.gov, 2022 Nov 17, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9671680/

[8]Adderton J., Are Patients Cared for Equally? Challenges of the VIP Patient, All Nurses, allnurses.com, Accessed 2024 Aug 1, https://allnurses.com/are-patients-cared-equally-challenges-t693358/

[9]Coulter A., Oldham J., Person-centered care: what is it and how do we get there?, National Library of Medicine, ncbi.nlm.nih.gov, 2016 Jun, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6465833/ (August 1, 2024)

[10]Schlossberg J.A., Let's talk about 'VIP syndrome', UCLA Health, uclahealth.org, 2020 Oct 13, https://www.uclahealth.org/news/article/lets-talk-about-vip-syndrome

California State Propositions on the November 2024 Ballot

by Gabriela Villanueva

The November election is fast approaching and once again includes a long list of propositions with the potential to significantly impact state issues and policies.

The following are the 10 propositions that will appear on the California general election ballot on November 5th:

Prop. 2 - Public Education Facilities Bond Measure:
This is a legislatively referred bond that would issue $10 billion in bonds, with $8.5 billion dedicated to elementary and secondary school facilities and $1.5 billion for community college facilities. Voters last approved a $9 billion bond measure to fund public education facilities improvements in 2016 and rejected a $15 billion bond measure in 2020.

Prop. 3 - Same-Sex Marriage:
This is a constitutional amendment to remove outdated language from Prop. 8. In 2008, Prop. 8 defined marriage as only between a man and a woman. Prop 3 would enshrine the right to same-sex marriage into the California constitution, repealing Prop 8. In practice, the ballot measure would not change who can marry. While Prop 8 language is still on the books, it was effectively void after the U.S. Supreme Court allowed same-sex marriage to resume in California in 2013, and after the high court legalized same-sex marriage nationwide in a historic 2015 decision.

Prop. 4 - Parks, Environment, Energy, and Water Bond Measure:
This is another legislatively referred bond that would authorize the state to issue $10 billion in bonds to fund various environmental, energy, and water projects. Some of the proposed initiatives include wind turbine development, state park repairs and renovations, farmland and farmworker support, coastal area restorations, and increased quantity and quality of water supply. It would also require that 40% of the bond revenue be used to fund activities that benefit communities with lower incomes or that are affected by environmental changes or disasters.

Prop. 5 - Changing Voting Thresholds for Bond Approval:
This is another state constitutional amendment that would lower the current majority required to approve local bond measures from a two-thirds vote to 55%. Cities and counties use bond measures to fund items like affordable housing construction, public infrastructure projects, including water management, local hospitals, police stations, broadband networks, and parks. To avoid opposition by the powerful California Realtors Association, the initiative also now includes a ban on local governments using the money to buy up existing single-family homes to convert them into affordable units.

Prop. 6 - Limit Forced Labor in State Prisons:
Prop. 6 would amend the state constitution to prohibit the state from punishing inmates with involuntary work assignments and from disciplining those who refuse to work. Instead, state prisons could set up a volunteer work assignment program to take time off an inmate's sentence in the form of credits. It would also allow county or city ordinances to establish a pay scale for inmates in local jails.

Prop. 32 - Increasing State Minimum Wage:
Prop. 32 would raise the minimum wage to $17 an hour for the remainder of 2024, and $18 an hour starting in January 2025—a bump from the current $16 an hour. Small businesses with 25 or fewer employees would be required to start paying at least $17 an hour next year, and $18 an hour in 2026. If passed by voters, California will have the nation's highest state minimum wage. Starting in 2027, the wage would be adjusted based on inflation.

continued on page 9

Continued from page 8

Prop. 33 - Local Rent Control:

The Costa-Hawkins Rental Housing Act is long-established law that imposes limits on the amount set by cities that a landlord can raise the rent each year. Cities cannot set rent control on single-family homes or apartments built after 1995. Currently, landlords are free to set their own rental rates when new tenants move in. If Prop. 33 is approved, cities will be allowed to control rents on ANY type of housing, including single-family homes and new apartments. This will be a highly contested fight with the opposition currently outspending the ballot supporters 3-to-1.

Prop. 34 - Use of Prescription Drug Revenue for Patients:

Occasionally, a proposition appears on the ballot and serves as a reminder of how this citizen-run process can be abused. Prop. 34 is arguably one of those propositions.

Technically, Prop. 34 would require some California healthcare providers to spend at least 98% of their net drug sale revenue on "direct patient care." But the proposition doesn't apply to all healthcare providers—only those that spend at least $100 million on expenses other than direct care, and who also own and operate apartment buildings that have racked up at least 500 severe health and safety violations in the last decade. Curiously, only one organization fits into this category: The AIDS Healthcare Foundation.

The foundation operates HIV/AIDS clinics in 15 states and has become a major player in state and local housing politics. It has aggressively lobbied and campaigned against legislation requiring local governments to permit denser housing, and has poured millions of dollars into rent control measures, including Prop. 33. Along the way, the foundation has amassed a sizable portfolio of rental properties in LA's Skid Row area. The California Apartment Association, the state's premier landlord lobby and a major opponent of rent control, is funding this initiative. The proposition has already been the subject of an ongoing legal battle, which may escalate even further if it passes.

Prop. 35 - Making the Managed Care Organization (MCO) Tax Permanent:

Lawmakers have dramatically expanded Medi-Cal in the past 10 years to cover all low-income residents regardless of citizenship status. Benefits have also been restored to include dental insurance, hearing aids, and doulas. Today, more than 14 million Californians use Medi-Cal. Over the same time period, payments to doctors and other Medi-Cal providers have increased only minimally, if at all. According to the Kaiser Family Foundation, California's reimbursement rate falls in the bottom third nationally. As a result, many providers won't treat Medi-Cal patients. In 2024, the state implemented an MCO tax, a provider tax by the state on managed care plans. The MCO tax generated a substantial amount of new funding for the state, with the premise that the funds would be spent to further invest in Medi-Cal. However, the funds have been targeted for diversion into other general purposes to fill the state's budget needs.

Prop. 35 would require the state to spend the money only on Medi-Cal and not deviate it to the general fund for other purposes. The new revenue stream would go to primary and specialty care, emergency services, family planning, mental health, prescription drugs, and increased payments to the providers themselves. It would also prevent legislators from using the tax revenue to replace existing state Medi-Cal spending. Over the next four years, it is projected to generate upwards of $35 billion.

Prop. 36 - Increase Drug and Theft Penalties and Reduce Homelessness Initiative:

This measure is meant to reform Prop. 47, a 2014 voter-approved measure that reduced penalties for certain theft and drug offenses. For retail theft,

continued on page 10

Continued from page 9

Prop. 47 increased the dollar amount from $400 to $950 for when thefts could be prosecuted as a felony. The idea was to reduce overcrowding in the state's jails. If voters approve Prop. 36, people with at least two prior theft convictions could be charged with felonies, even if what's stolen is less than $950. Prop. 36 would also allow judges to sentence drug dealers to state prison rather than county jail if convicted of trafficking hard drugs in large quantities or possessing a firearm while trafficking drugs. The proposition does call for treatment plans for those who plead guilty to felony drug possessions, which could result in dismissed charges.

For more details on the propositions, visit: **https://www.sos.ca.gov/elections/ballot-measures/qualified-ballot-measures**

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Making Changes to Your Practice? Update Your Membership Information To Help With Your Year-End Planning

If you are considering a change in your practice this year or in 2025, please notify CAP as soon as possible. Our Membership Services team can work with you to ensure that any necessary coverage transitions are implemented smoothly.

Changes include, but are not limited to:

- Retirement from practice at age 55+
- Part-time practice (e.g., 20 or fewer hours per week or 16 hours for anesthesiologists)
- Reduction or any change in the scope of your practice
- Employment with a government agency or non-private practice setting
- Employment with an HMO or other self-insured organization
- Joining a practice insured by another carrier
- Moving out of state
- Termination of CAP membership

The Mutual Protection Trust (MPT) Board of Trustees will levy an assessment in November 2024. To allow ample processing time, we strongly recommend that you provide any updates to CAP no later than October 31, 2024, to be evaluated for reductions or proration of the 2025 assessment.

The online coverage update form is now available in the Member's Area of the CAP website at **https://member.CAPphysicians.com**.

If you have not yet registered for the Member's Area, please register for an account at **https://member.CAPphysicians.com/register**.

You will need your member number and the last four digits of your Social Security number.

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continued on page 12

Continued from page 11

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OCTOBER 2024

Ask My Practice

By Andie Tena

Important Update to SB 525, the Healthcare Minimum Wage Law

As many physicians are aware, Governor Newson signed Senate Bill 525 (SB 525), the healthcare minimum wage bill, into law in October of 2023. Originally approved to take effect on June 1, 2024, SB 525 requires certain healthcare facilities to pay a special minimum wage to their employees based on a tiered implementation schedule.

Due to the immense impact on the state budget, the effective date of SB 525 was pushed back to July 1st of 2024 to allow for further review of the state budget and the impact that SB 525 would have on California. The implementation date was yet again pushed back to October 15th of 2024.

The October 15th deadline was contingent upon the state bringing in at least a 3% increase in revenue than is currently expected in first quarter of the upcoming fiscal year or upon the collection of data that would allow for federal funding.[1] According to Ana B. Ibarra of CalMatters, the implementation of SB 525 will cost the State of California $4 billion, of which half would come from the state's general fund which is facing a projected $28 billion deficit.[1]

After several delays, SB 525 is effective as of October 16, 2024. Although small independent medical offices with fewer than twenty-five physicians are generally exempt from SB 525, many have already implemented a tiered pay increase in their budgets due to hiring competition in the healthcare space.

For those practices or entities to which SB 525 applies, immediate action is required to implement the minimum wage increase schedule, if they have not already done so.

For additional information or guidance, please contact CAP's Assistant Vice President of Practice Management Services, Andie Tena at 213-473-8630.

[1]Ibarra, Ana B., "California's new health care minimum wage is changing. Here are answers to your questions," CalMatters, June 22, 2024, https://calmatters.org/health/2024/06/health-care-minimum-wage/

Andie Tena is CAP's Assistant Vice President of Practice Management Services. Questions or comments related to this column should be directed to ATena@CAPphysicians.com.

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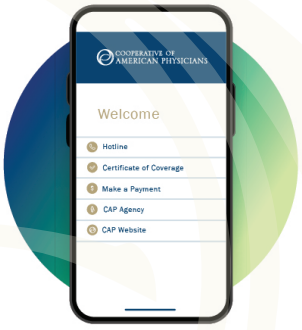

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IN THIS ISSUE

OCTOBER 2024

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