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On The Hill
New Requirements for
Vaccination Exemptions
on the Horizon

Hot Button Issue
California Legislation
Aims to Improve
Discharge Planning for
a Vulnerable Patient
Population

Risk Management
"You Didn't Tell Me
That!" Informed Refusal
as a Defense

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JANUARY 2020

IN THIS ISSUE

01 A MESSAGE FROM THE CEO

02 ON THE HILL

California Law for License Probation Disclosure

New Requirements for Vaccination Exemptions on the Horizon

05 HOT BUTTON ISSUE

California Legislation Aims to Improve Discharge Planning for a Vulnerable Patient Population

08 RISK MANAGEMENT

“You Didn’t Tell Me That!” Informed Refusal as a Defense

10 DEAR CAPPY

Weird Calls

Starting My Own Practice

12 YOUR FINANCIAL HEALTH

Life Insurance Dos and Don’ts

14 THE OFFICE

#MeToo Movement and Its Impact on Business Owners: What You Need to Know to Protect Yourself

Protect Your Medical Office from a Business Associate Breach

18 MEDICINE ON TRIAL

Attending Surgeries With Limited On Call: Who Will Have Your Back?

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A MESSAGE FROM THE CEO



We don't have to revisit the history of the Gold Rush to understand why California is nicknamed the Golden State. California has the fifth largest economy in the world and the largest gross domestic product in the United States. At the same time, a concern over the shortage of physicians has been part of the conversation for some time. A recent study shows that California does not have enough primary care physicians in most regions of the state; and the situation will only grow more acute due to an aging physician workforce and a growing population.

A popular saying is "As California goes, so goes the nation." California has long been considered a state where social and political change is on the cutting edge of issues—to the pleasure or displeasure of many, depending on the issue.

It is not an exaggeration to say that California doctors face challenges that are unique from the rest of the country. California is home to over 25% of the nation's homeless, and the number is expected to increase. You may have seen the headlines about the vaccination-related legislation in the state. California has also been at the forefront of protecting patients, as evidenced by the landmark "Patient's Right to Know Act" that went into effect earlier this year.

This edition of *Physician Today*® discusses current trends and legislative updates impacting California physicians like you. In addition to state-specific issues, you will read about the #MeToo movement's potential impact on business owners, the ins and outs of purchasing life insurance, and tips on discussing informed refusal with your patients.

No matter where you practice in California, I hope you find this issue informative and useful. If you would like additional copies of *Physician Today* for your office or colleagues, contact us at communications@CAPphysicians.com.

Sincerely,

A handwritten signature in black ink, appearing to read "S. Scher".

Sarah E. Scher, JD
Chief Executive Officer
Cooperative of American Physicians, Inc.

P.S. You may have noticed that my byline is different from the previous edition. I recently got married and changed my last name from Pacini to Scher.

ON THE HILL

California Law for License Probation Disclosure

Gabriela Villanueva
Public Affairs Analyst, CAP

A California law requiring practitioners to disclose a probation status to their patients went into effect on July 1, 2019.



In September 2018, then-Governor Jerry Brown signed the “Patient’s Right to Know Act of 2018” (SB 1448 by Senator Jerry Hill, D-San Mateo), the first-in-the-nation law requiring practitioners to notify their patients if their license is on probation for the following offenses:

- Any act of sexual abuse, misconduct, or relations with a patient or client;
- Drug or alcohol abuse directly resulting in harm to patients or to the extent that such use impairs the ability of the practitioner to practice safely;
- Criminal conviction directly involving harm to patient health; or
- Inappropriate prescribing resulting in harm to patients and a probationary period of five years or more.

Previously, when a physician was put on probation, he or she was only legally required to notify their malpractice coverage provider and any affiliated hospitals or clinics. Under the new law, all physicians disciplined by the Medical Board of California (MBC) will be required to obtain a signed disclosure

from all patients before a patient’s next appointment. The disclosure must include:


1. The physician’s probation status.
2. The length of the probation and end date.
3. The practice restrictions placed on the medical licensee by the MBC.
4. An explanation of how the patient can find further information about the licensee’s probation on the licensee’s MBC website profile page.

The law applies to physicians and surgeons, chiropractors, podiatrists, and acupuncturists.

The MBC has long carried physician information on its website but amendments to the law placed the focus on the minority of doctors who commit egregious misconduct. “We never tried to protect those doctors, and we never will,” said Ted Mazer, MD, CAP member, and past president of the California Medical Association, when interviewed by a local news channel. Dr. Mazer added that it was important to the CMA that physicians who had been disciplined for lesser wrongdoings that did no harm to patients—such as deficits in medical recordkeeping—would not have to reveal such disciplinary action to their patients. [🔗](#)

New Requirements for Vaccination Exemptions on the Horizon

Gabriela Villanueva
Public Affairs Analyst, CAP



California state Senator and pediatrician Dr. Richard Pan (D-Sacramento) introduced multiple vaccination-related legislation during his tenure as Chair of the Senate Health Committee. SB 277 was passed in 2015 to eliminate all non-medical (i.e., religious and personal belief) exemptions for immunizations required for school entry. According to the California Department of Public Health (CDPH), while SB 277 was successful in raising immunization rates across the state, there was also an increase in the number of medical exemptions issued. CDPH notes the percentage of kindergarteners with medical exemptions rose from 0.2 percent

of students in the 2014-2015 school year to 0.9 percent of students in 2018-19.

At a time when there has been a rise of medical exemptions in the state, and in a year that has seen the worst measles epidemic in 27 years, vaccination-related legislation returned front and center at the state Capitol in 2019, making it one of the year's most contentious issues.

According to the Centers for Disease Control website, from January 1 to September 12, 2019, 1,241 individual cases of measles were confirmed in 31 states, including California.

continued

Back in February 2019, Dr. Pan introduced SB 276 to address what he considered the dramatic increase in medical exemptions from vaccinations required for school entry.

The bill went through several iterations, as discussions prompted multiple amendments throughout the committee hearing process, as well as discussions with the Governor's Office, which was closely following the developments.

In its final version, signed into law by Governor Newsom, SB 276 will require:

- By January 1, 2021, CDPH shall develop and make available for use by licensed physicians and surgeons an electronic, standardized, statewide medical exemption certification form that shall be transmitted directly to the department's California Immunization Registry (CAIR). The form shall be printed, signed, and submitted directly to the school or institution at which the child will attend, submitted directly to the governing authority of the school or institution, or submitted to that governing authority through CAIR, where applicable.
- CDPH will annually review exemption forms that meet any of the following criteria: 1) submitted to schools with overall immunizations rates less than 95 percent; 2) submitted by physicians who have granted more than five medical exemptions in one year; or 3) submitted to schools that have failed to report their immunization records to CDPH.

- The State Public Health Officer or a physician designee may deny or revoke medical exemptions that do not align with CDC/ACIP or AAP guidelines if the exemption is determined to be inconsistent with standard of care.

- The Department will notify the Medical Board of California of any physician who submits an exemption that is denied or revoked, and of any physician from whom the Department is not accepting exemptions.

- The Department will not accept medical exemptions from physicians who pose a risk to the public's health, or from physicians with pending accusations with the Medical Board of California until the accusation is resolved in favor of the physician.

- The bill will authorize a parent or guardian to appeal a medical exemption denial or revocation to the Secretary of California Health and Human Services. The appeal would be conducted by an independent expert review panel of licensed physicians and surgeons established by the secretary. The bill would require the independent expert review panel to evaluate appeals consistent with specified guidelines and to submit its decision to the secretary.

In signing SB 276, Governor Newsom also signed a companion bill, SB 714, which allows a child who has a medical exemption issued before January 1, 2020, to be valid until the child enrolls in the next grade span. 🌐

HOT BUTTON ISSUE

CAPAssurance
Risk Management Department



California Legislation Aims to Improve Discharge Planning for a Vulnerable Patient Population

To describe homelessness as a “complicating factor” in healthcare is a gross understatement; the homeless die nearly three decades earlier than the general population, and their health challenges are innumerable.¹ Addiction, mental illness, malnutrition, exposure to a host of infectious diseases related to overcrowding, poor hygiene, a lack of sanitation and IV drug use, as well as the threat of violence, routinely undermine the health and well-being of this population. For the homeless, healthcare access is at best episodic, and is often driven by the need for urgent treatment.

Studies estimate that those experiencing homelessness are four times more likely than low-income residents to use emergency room services.² A lack of access to primary care and preventive health services places homeless patients at increased risk for late stage diagnosis of disease.³ Mental illness, common in this population, coupled with logistical and economic challenges, make the management of chronic diseases such as asthma and diabetes nearly impossible. Understandably, healthcare professionals are confounded as to how to effect sustainable improvement in the health and well-being of their homeless patients.

continued

California is home to over one-quarter of the nation's homeless, roughly 114,000-130,000 people, and the number is expected to increase.⁴



Although overcoming the health disparities of homelessness defies an easy solution, recent legislation focusing on treatment, screening, and improved care coordination with social services and community partners may help ease the transition for homeless patients at discharge.

In 2018, in response to news stories of homeless patients unfit for discharge being “dumped” on skid row, Governor Brown signed legislation requiring hospitals to expand current efforts surrounding discharge planning for homeless patients.

Effective January 2019, SB 1152 requires hospitals to establish a homeless patient discharge planning policy incorporated into

the current discharge policy or included as an addendum. The purpose of the policy is to create an individualized discharge plan for homeless patients to “help prepare the homeless patient for return to the community by connecting him or her with available community resources, treatment, shelter, and other supportive services.”

The following are a few of the key provisions in effect since January 2019:

- **Housing/Shelter:** Hospitals must inquire about a patient’s housing status and identify a post-discharge destination for the patient. Unless a patient requires continued care at another licensed health facility, priority should be given to a sheltered destination with supportive services.

Prior to discharging homeless patients, hospitals must offer the following services:

- **Medical Screening Exam:** Treating physicians must provide and document a medical screening examination and evaluation of the patient (an existing requirement under the Emergency Medical Treatment & Labor Act (EMTALA)) and assess whether the patient is oriented to person, place, and time. Physicians must also determine a patient’s clinical stability for discharge.

- **Post-Discharge Care and Referrals:** In a culturally competent manner and in a language that is understood by the homeless patient, healthcare providers

must communicate post-discharge needs to the patient and refer the patient for follow-up care. If behavioral healthcare is needed, the patient shall be treated or referred to an appropriate provider.

■ **Contacting Health Plan, Caregivers, and Primary Care Provider (PCP):** The hospital must demonstrate good faith efforts to contact the patient's health plan if they are currently enrolled, the patient's identified primary care provider, or another appropriate primary care provider, including but not limited to a coordinated entry system.

■ **Screening for Affordable Health Coverage:** Hospitals must provide screening and assistance for enrolling patients in any affordable healthcare coverage for which they are eligible.

■ **Infection Disease Screening:** Hospitals must offer screening for infectious diseases common to the region, or refer the patient for screening at a county clinic. Hospitals may consult with the local public health officer for guidance on appropriate screenings.

■ **Vaccines:** Hospitals must offer vaccinations appropriate to the patient's presenting medical condition and provide the federal vaccine information statement.

■ **Nutrition:** Hospitals must offer patients a meal before discharge.

■ **Clothing:** Hospitals must assess if the patient's clothing is weather-appropriate and offer proper clothing as needed.

■ **Medications:** Hospitals must provide

prescriptions to homeless patients requiring medication. Further, if the hospital has an onsite pharmacy licensed to dispense outpatient meds, the patient must be given an appropriate supply of all necessary medications.

■ **Transportation:** At discharge, the hospital must offer homeless patients transportation to discharge destinations within 30 miles or 30 minutes from the hospital.

Additional Requirements to Coordinate Services and Referrals

In addition to the requirements outlined above, as of July 1, 2019, hospitals must implement a written plan for coordinating services and referrals for homeless patients with community partners, including county behavioral health agencies, healthcare professionals, regional healthcare and social services agencies, and nonprofit social services providers.

Finally, the hospital must maintain a log of homeless patients and their discharge destinations and must document compliance with the discharge protocol. ©

Sources:

¹Hayashi, Seiji. "How Health and Homelessness are Connected-Medically." *The Atlantic*. January 25, 2016

²Ibid.

³Stafford, Amanda; Wood, Lisa. "Tackling Health Disparities for People Who Are Homeless? Start with Social Determinants." *International Journal of Environmental Research and Public Health*. December 14, 2017

⁴Medina, Jennifer. "California Today: State's Homeless Population Drives National Increase." *The New York Times*. December 21, 2017

For further information on this subject, see the California Hospital Association guidebook *Discharge Planning for Homeless Patients* at <https://www.calhospital.org/cha-news-article/homeless-patient-discharge-planning-guidebook-now-available-free-download>

RISK MANAGEMENT

“You Didn’t Tell Me That!” Informed Refusal as a Defense

Deborah Kichler
Senior Risk Manager, CAP

The age-old discussion of “informed consent” and “the consent form” never ceases. A procedure or treatment is scheduled and there is an order to obtain the patient’s consent. The nurse takes the consent form to the patient for signature and the patient inquires, “What am I signing? I have not spoken to the doctor yet.” A common allegation in malpractice lawsuits is the failure to obtain the patient’s consent for treatment. It goes beyond just getting the patient to sign a piece of paper.

The cornerstone of the informed consent process is the discussion between the physician and the patient.

A patient has the right to consent (or not) to any recommended medical procedure or treatment.

The patient also has the right to enough information to give an informed and meaningful consent. Before proceeding, the patient should be informed about the proposed procedure or treatment; the risks, benefits, and alternatives; as well as the risks and benefits of any alternative treatments. This informed

consent discussion, as well as any written materials and videos, must be provided in a language that the patient understands. The discussion should include enough information so that the patient has a clear understanding and can make an informed decision whether or not to undergo the proposed procedure or treatment. Include a copy of the written materials, drawings, photographs, and names of videos reviewed with the patient in the medical record as part of the informed consent discussion documentation.

The patient also has the right to refuse the proposed procedure or treatment. In this case, the physician should ensure that the patient understands the risks and consequences that may result from the decision to refuse, or failure to pursue, a recommended medical procedure. This documentation must be thoroughly noted in the medical record, as above.

Patient refusal and documentation also applies to a physician’s recommendation that a patient see a specialist. The patient should be informed of the reasons for the recommendation and the possible consequences if the patient fails to obtain a specialist’s advice.

Another example of refusal occurs when there is a patient emergency in the office that triggers a need for Emergency Medical Services (EMS) transport. If the patient refuses to utilize the EMS transport, the healthcare provider should explain to the patient and family, regardless of the distance, that the ambulance service is the safest mode of vehicle transportation. If the patient opts to go by private vehicle, document the informed refusal discussion in the medical record.

In litigated cases, jury instructions related to informed refusal include: “A (physician) must explain the risks of refusing a procedure in language that a patient can understand. The patient should be given as much information as he/she needs to make an informed decision, including any risk that a reasonable person would consider important in deciding not to have the said procedure/treatment. The patient must be told about any risk of death, serious injury, or significant potential complications that may occur if the procedure/treatment is refused. A physician is not required to explain minor risks that are not likely to occur.” (CACI No. 534)

Tips for Patient Discussion

1. Provide enough information so the patient can make an educated decision whether or not to agree to the proposed procedure or treatment.
2. Provide the information in the language the patient understands. Provide written materials, drawings, and videos to assist in discussion.

3. Evaluate the patient’s understanding through teach-back methods; ask open-ended questions, allow time for patient questions.
4. Identify an alternative treatment plan.
5. Obtain the patient’s signature, if possible, if the patient refuses the procedure or treatment. (Perhaps have a witness present when a patient refuses treatment.)
6. Document your discussion: diagnosis, proposed procedure/treatment, prognosis, risks and benefits of treatment and alternative treatments, and the consequences of refusing treatment. Whether your patient is refusing a surgical procedure, a medical treatment, referral for follow up, or other situation, document the discussion (risks, benefits, alternatives, and consequences) in the medical record. ☺



Dear Cappy

ADVICE COLUMN

Weird Calls

Dear Cappy,

My office has been receiving weird calls lately. The other day I received a call from someone claiming to be a pharmacist who said he needed my DEA number. When I started to ask questions, the caller was very rude and then hung up on me!

My receptionist fielded a different call from someone who said he was from the DEA. The caller demanded that she turn herself in to local law enforcement for writing fraudulent prescriptions. He was so intimidating and persistent that my receptionist became suspicious and abruptly ended the call. What is going on?

Dr. Suspicious

Dear Dr. Suspicious,

Unfortunately, calls such as this are becoming more common. If you or your office staff receive calls like this, CAP's Risk Management and Patient Safety Specialists urge you to report them to your local DEA Division office. Their official website reminds us that agents never contact members of the public by telephone to demand money or any other form of payment. They instruct the public to complete the "Extortion Scam Online Reporting" form (see link below) in order to assist them with investigating and stopping this criminal activity. We encourage you to report these calls to the FBI and your local police department.

Visit this for the DEA's Diversion Control Division Alert-Extortion Scam and to access the reporting form: <https://apps2.deadiversion.usdoj.gov/esor/spring/main?execution=e1s1>

Moreover, the Los Angeles Police Department offers these crime prevention tips to avoid falling victim to telephone extortion scams. Be aware of the following:

- Incoming calls made from an outside area code or country.
- Callers who go to great lengths to keep you on the phone and insist that you remain on the line.
- Calls that do not come from a recognized phone number or from the "victim."
- Callers who try to prevent you from contacting the "victim."
- Multiple successive phone calls.
- Demands for ransom money or fines for payment via wire transfer.
- Callers who demand immediate payment for any reason.
- Never give out personal or financial information to anyone who emails or calls you unsolicited.
- Never wire money or provide debit or credit card numbers to someone you do not know.

Remain vigilant and stay safe!

Cappy

Starting My Own Practice

Dear Cappy,

I've been working at a hospital for a number of years and I'm ready to set up my own shop. My smart aleck brother-in-law insists that I need to hire him as my attorney before I even find an office space. I'm trying to keep my costs low and he won't even offer me a family discount. Can't I just figure it out as I go along?

Dr. Just Wing It

**Dear Dr.
Just Wing It,**

I hate to break it to you, but your brother-in-law is absolutely right about getting legal advice! Unless you possess exceptional business acumen, surround yourself with a team of expert consultants who will be invaluable in helping reduce stress and increase your short-term and long-term profitability. Here are three key players to include on your planning team:

- 1. Accountant** – Assists with such tasks as entity setup, filing for business licenses, incorporation filings, expense tracking, long- and short-term financial planning, and more.
- 2. Attorney/Legal Advisor** – Provides valuable advice on corporate structure, negotiation of agreements, drafting of contracts, etc.
- 3. Practice Startup Consultant** – Plays a pivotal role in hiring and training staff, negotiating with vendors, choosing the right type of equipment, managing the planning process, overseeing the critical credentialing process, and more.

Bring on your teammates as soon as possible, as they will play an instrumental role in helping you create a business plan/pro forma and secure the best type of funding.

Cappy



For more information, request a free copy,
*The Physician's Action Guide to Starting
Your Own Practice*

www.CAPphysicians.com/syopPT3 or
800-356-5672.

Your Financial Health



Life Insurance Dos and Don'ts

Ravi Davis, CFP
Hippocratic Financial Advisors

Physicians come out of medical school highly educated and anticipating a career that will be rewarding in every way—including monetarily. Not surprisingly, this makes them perfect targets for people who sell life insurance.

Doctors have more money than time, and are justifiably proud of their ability to grasp complex subjects quickly. But what life insurance agents know that most doctors don't is that there are a wide range of life insurance products available. However, the most expensive, most profitable products may not be the best ones for every doctor. When it comes to medicine, the average doctor knows far more than the average life insurance agent ever will. But when it comes to life insurance, it's surprisingly easy to get fooled, unless you're willing to

take the time to really dig into the details and know the right questions to ask.

Life Insurance Basics

There are three main kinds of whole or permanent life insurance: traditional whole life; universal life; and variable universal life. But it gets confusing fast, with variations, sub-types, and sub-categories.

Doctors are aggressively sold cash value (permanent) life insurance, which combines an investment product with life insurance. It often sounds appealing to young doctors who don't have time to invest.

These are really profitable policies for the agent to sell, for a number of reasons.

First, these policies are complex, with substantial downstream potential tax implications for funding or not funding the policy at specified levels. Second, there are fees that really add up over time.

These policies cost much more than term life insurance, which is more straightforward. It's like car insurance—pay every month and hope you'll never use it.

It's called "term" insurance because the policy has a specific monthly cost for a specific term. Rather than an open contract that runs for life, you choose a 10, 20, or 30-year term.

When Should You Buy Life Insurance?

It's best to buy when you're young and healthy, to lock in a long-term strategy.

Buy when you have dependents: a spouse, children, or parents who are dependent. You'll need more life insurance when you're young, and the family can't afford to lose your income. You'll need less as you get older, which should be a consideration when estate planning.

It's Good to Diversify

Buy from different insurance companies and "stack" your coverage: a 10-year term policy from one firm, 20-year term from another, and a 30-year term from a third. As your wealth grows and risk shrinks, you can pare your coverage back.

Summary: Life Insurance Dos and Don'ts

Do talk to a broker or independent agent. They work for you, not the life insurance company. They'll help you navigate the complexities.

Do work with brokers or independent agencies that specialize in working with doctors.

Don't speak only to a captive agent who works for a life insurance company. Their incentive is to sell you the most profitable policy they can.

Do buy term insurance—it's the right answer 95 percent of the time. ©



Ravi Davis is founder of Hippocratic Financial Advisors, an organization dedicated to growing a physician's financial health and well-being. For questions about this article, please call 866-447-2380.

THE OFFICE

#MeToo Movement and Its Impact on Business Owners: What You Need to Know to Protect Yourself

Deidre Hoppe
President and CEO, CAP Physicians Insurance Agency, Inc.

According to a new report on sexual harassment released by the Equal Employment Opportunity Commission (EEOC), data for fiscal year 2018 show a more than 50 percent increase in sexual harassment lawsuits filed by the agency, and a more than 12 percent increase in the number of charges it received over fiscal year 2017. The EEOC also reported that hits on its sexual harassment web page doubled over the last year. It should come as no surprise to you that the EEOC's 2018 fiscal year data coincided with the start of the #MeToo movement.

What may come as a surprise is the fact that the average cost to defend an employment practices lawsuit is \$150,000, while the average cost of settlement is \$200,000. The cost to employers for an employment practices claim includes defense costs and payment of damages, and a practice must defend itself whether or not there is merit in a lawsuit. In fact, it can cost thousands of dollars to simply respond to an EEOC charge without any lawsuit. Employment Practices Liability Insurance (EPLI) will easily pay for itself if you are sued even once.

EPLI is insurance that protects you against employee claims alleging wrongful termination, sexual harassment, and discrimination. Most employers don't realize that EPLI can be extended to cover claims made by third parties, such as vendors or employees at a hospital. You can also add wage and hourly coverage that will protect you from employees alleging they did not get breaks, time off, or overtime pay.

The cost of an EPLI policy is a fraction of what you would pay if you end up on the losing side in a lawsuit. EPLI premiums will vary depending on a number of factors:

- Number of employees
- Amount of coverage purchased
- Whether your company has anti-discrimination and anti-harassment human resources policies in place
- Whether your company has had any EEOC complaints or lawsuits filed against it in the past

Members of the Cooperative of American Physicians, Inc. (CAP) automatically receive the employment practices benefit of



\$50,000 in defense costs reimbursement only. However, unless you have an EPLI policy, your business is not protected from potential employee lawsuit payments and associated costs. According to an industry study, six out of 10 non-buyers of EPLI coverage mistakenly think they are protected by other forms of insurance.

You owe it to yourself and your practice to get a quote. CAP Agency is ready to help CAP members protect their practice. Contact us at **800-819-0061** or email us at **CAPAgency@CAPphysicians.com** for more information. ☺



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www.CAPphysicians.com/insPT3

Protect Your Medical Office from a Business Associate Breach

Jeff Mongelli
CEO, Acentec, Inc.

Potentially
compromised
patient records:
25 million



In 2018, there were a total of 74 different business associate healthcare breaches reported to the Federal Office of Civil Rights (OCR). In May 2019, three more providers were added to the tally of the American Medical Collection Agency breach victims, which has now seen more than 25 million patient records potentially compromised. This has become one of the largest healthcare breaches to date.

That means those affected covered entities could have been doing nearly everything right, but they still paid the price for the behavior of their vendors. And these are just the breaches that were reported. It's anyone's guess what the total count actually is, let alone the vendors who experienced a breach and never reported it to their covered entity clients.

What does this mean to a covered entity? It means that it's not enough to require a signed Business Associate Agreement (BAA). Vendors should be diligently vetted. Here's what you should be doing:



1. Make sure your vendor has completed a Security Risk Assessment. Ideally, this has been done within the past year. Ask for a copy for your records. Upon receipt, review the report. Does it specify it was conducted in accordance with the Health Insurance Portability and Accountability Act (HIPAA) requirements? Does it include a breakdown of vendor deficiencies, along with a remediation checklist and timeline? Can the vendor document that they are adhering to this remediation plan?



2. What workforce vetting practices are utilized by your vendor? A BAA won't prevent an unscrupulous employee of your vendor from stealing your data, most often for financial gain. The BAA may reduce your liability, but you'll still be implementing your Incident Response Plan and doing damage control on your reputation.



3. What protocols does your vendor document regarding how they handle their access, management, and storage of your Protected Health Information (PHI)? For example, it's not enough to accept your vendor's verbal assurances that they use encryption. Get it in writing, especially if you are using a generic BAA that doesn't narrowly define the scope of your vendor's provided services.



4. Don't buy the fancy stories. We are frequently amazed at the cleverness and inventiveness of the stories vendors come up with regarding why they're not required to sign a BAA. We understand why vendors don't want to consider themselves under the purview of the HIPAA laws, but if they act like a

Business Associate (BA) and do business like a BA, guess what? They're a BA. If you hear a negative story from or about your vendor, choose another vendor without delay. This includes a number of companies who are essentially household names. Company size or brand awareness doesn't mean they're following HIPAA requirements.

Finally, more and more hospitals and large healthcare organizations are tightening the scrutiny of their vendors. Numerous vendors have been replaced in the past few years by these institutions specifically because of their practices relating to HIPAA. We recommend that you follow suit. If you're working with a vendor that won't meet your security requirements, find another one. Put yourself in your vendor's shoes. If you're a vendor in the healthcare space and you haven't made HIPAA compliance and security a priority, you have no business being in healthcare. Don't enable companies who aren't willing to match or exceed your commitment to protecting your patient's data by hiring them. 🙅

Jeff Mongelli is CEO of Acentec, Inc., a nationwide provider of HIPAA compliance and medical IT management services. If you have any questions about this article or would like recommendations, please contact him for a free consultation at 800-970-0402 or jeffm@acentec.com.

MEDICINE ON TRIAL

Attending Surgeries With Limited On Call: Who Will Have Your Back?

When attending to a weekend surgery at the hospital, make sure you don't find yourself all alone with too much to do.



Gordon Ownby, JD
General Counsel, CAP



A 61-year-old patient was the only scheduled surgery on a Saturday morning, where he was to undergo an endoscopic retrograde cholangio-pancreatography (ERCP) for suspected inflamed gallbladder/bile duct gallstones. The gentleman had Type 2 diabetes, major depressive disorder, essential hypertension, and a remote history of a cerebrovascular accident (CVA). Dr. A, the anesthesiologist for the surgery, classified the patient as ASA III and anticipated a difficult intubation.

On the morning of the scheduled surgery, Dr. A—the only anesthesiologist on call at the hospital that weekend—learned that he was also to attend to a Cesarean section for a patient with failed labor.

The ERCP started at 8:15 that morning and after a difficult intubation proceeded without incident. Surgery concluded at 9:25 a.m. but hospital staff notes at 9:35 a.m. showed the extubated, bag-masked patient in the post-anesthesia care unit (PACU) as unresponsive. Dr. A ordered new dosages of relaxant-reversals without improvement. Dr. A then re-administered a muscle relaxant and attempted to re-intubate the patient. When the reintubation failed, Dr. A was successful in placing a laryngeal mask airway (LMA). At 10:00 a.m. with the LMA in place and connected to a ventilator, Dr. A left the patient in the

continued


care of the nursing staff and respiratory therapists as he began general anesthesia for the Cesarean section in the operating room next door.

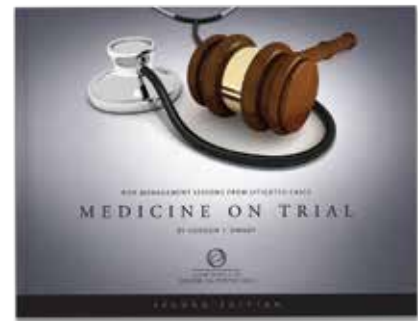
With Dr. A at the Cesarean section, the GI patient desaturated and staff called the emergency room physician, who arrived at 10:05 a.m. According to his records, the ER physician noted no breath sounds or chest rise. The ER physician asked the staff to call Dr. A back to the PACU stat to re-establish an airway and to call any other available anesthesiologist—as well as a general surgeon in the event of a cricothyrotomy. The ER physician made several unsuccessful attempts to intubate the patient and began an emergency cricothyrotomy when Dr. A returned to the PACU. The ER physician asked Dr. A to assist in establishing an airway, but Dr. A stated he did not think he could do that successfully as he had previously been unable to re-intubate the patient and that he needed to return to the Cesarean delivery. The ER physician unsuccessfully attempted the cricothyrotomy and a Code Blue was called at 10:22 a.m. Another anesthesiologist arrived at 10:40 a.m. and successfully intubated the patient. The patient remained pulseless, however, and was declared dead at 11:07 a.m.

In a subsequent lawsuit, the family sued Dr. A for medical negligence and for patient abandonment. Dr. A and the family resolved the litigation without going to trial.

In his deposition, Dr. A testified that he advised the obstetrics surgeon to speak to the gastrointestinal surgeon regarding

whether the Cesarean delivery could be performed first. No such change occurred. Dr. A also testified that staff was unable to get another anesthesiologist to take the Cesarean section or to get a surgeon for a possible cricothyrotomy.

Jurors expect physicians to make more than just technical medical decisions: When a situation puts patient safety at risk, they will look for a physician's assertiveness. These are the times for the "patient's advocate" to be heard. 



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