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AMERICAN PHYSICIANS

Risk Management
Hold the Phone!
Risk Management
Insights into the Perks
and Pitfalls of Text
Messaging

Hot Button Issue
Medical Cannabis:
Know the Latest

On The Hill
Will Healthcare For All
Come to California?

PHYSICIAN

Managing a Safe and Successful Practice

Today

WRAPPING
YOUR MIND
AROUND THE
CURRENT
STATE OF
MEDICINE



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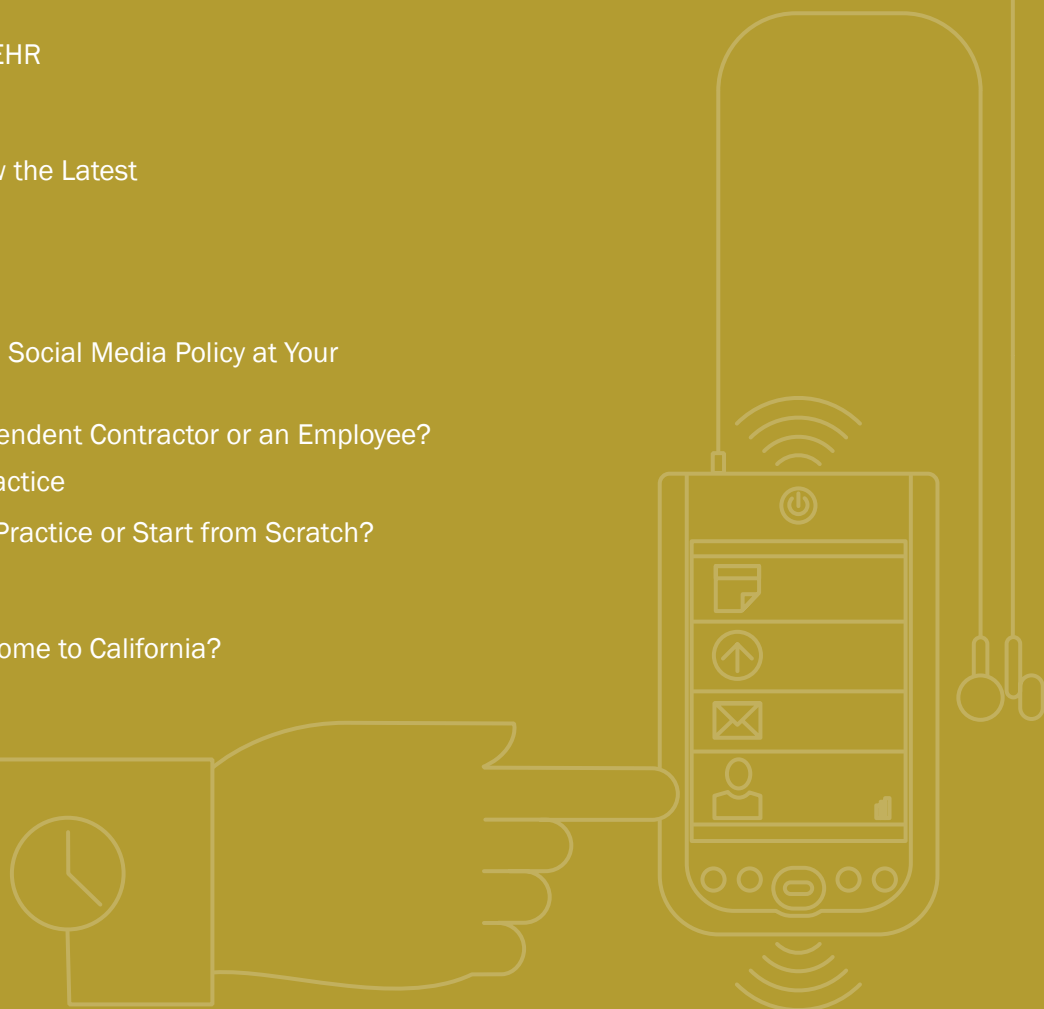
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A MESSAGE FROM THE CEO



We all read the headlines and know that physicians are facing enormous change at an alarming rate. This is especially true for independent physicians who must keep up with regulatory changes, healthcare consolidation, unprecedented compliance oversight, and all the other demands from entities that dictate how and when care should be delivered. When did the simple act of seeing patients become so burdensome for physicians?

Technology alone brings new risks every day, but not only from hackers and cyberthreats. Something that seems as innocuous as text messaging could lead to an unknowing HIPAA violation. How can you make sure your practice is safe from risk without going to the extreme of banning text messaging?

Technology also enables patients to have access to more information about ‘alternative’ treatments like medical cannabis. Individuals ages 55 to 65 are the fastest growing demographic of medicinal users. Will you be prepared to discuss risks, benefits, and side effects with your patients who ask about medical cannabis?

For all the changes we’ve seen, healing remains in many ways a business of brains, gut instincts, and judgment calls. Sometimes the most mundane situation can make or break your day. Should you let your medical assistant issue the refill on a prescription? What about a new prescription? How should you handle patients who come into the office with service dogs? Do you allow employees in your practice to use social media at work?

Whether you’re looking ahead to the future or firmly entrenched in what’s happening now, we can all agree that the private practice of medicine is not for the faint of heart. Independent medicine is for courageous healers, and it’s CAP’s job to help physicians like you offload some of the burden. As a physician-owned and governed organization, CAP always focuses on the long-standing and emerging challenges and opportunities that doctors face. I hope this issue of *Physician Today* gives you some answers to common concerns.

If you would like additional copies of *Physician Today* for your office or colleagues, or have recommendations on topics you’d like to see covered in future issues, contact us at communications@CAPphysicians.com.

We’d love to hear from you!

Sincerely,

A handwritten signature in black ink, appearing to read 'Sarah E. Pacini'.

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

RISK MANAGEMENT

Hold the Phone! Risk Management Insights into the Perks and Pitfalls of Text Messaging

*CAP Risk Management and
Patient Safety Department*

The ease, efficiency, and utility of text messaging isn't lost on healthcare professionals, 90 percent of whom use it as a method for sharing information with colleagues, patients, and staff. Although text messaging may be our new preferred mode of communication, enthusiasts are well advised to momentarily put down their mobile devices and educate themselves on the emerging best practice recommendations, existing legal restrictions, and the unique rules that currently govern provider-provider and provider-patient text messaging.

Rules and Recommendations for Provider-Provider Text Messaging

In December 2016, The Joint Commission issued a clarification statement establishing the following limitations on text messaging between providers:

Unencrypted text messaging of communications that include protected health information (PHI) is prohibited.

The standard short message service (SMS) that conveniently exists on your mobile device is considered a prohibited, unsecure texting platform—making all communications transmitted via

this medium vulnerable to hacking, unauthorized access, and a HIPAA violation. The Office of Civil Rights regards the use of an unencrypted text messaging service for the communication of PHI as a HIPAA breach. The fines for a breach of HIPAA can be quite high. The fine for a single breach of HIPAA can be up to \$50K per day if the vulnerability responsible for the breach is not attended to.

Here are a few examples that were found to be HIPAA violations while sending unencrypted text messages:

- A doctor texted a Medical Assistant (MA) on his personal mobile phone asking him to text the lab results for a patient the physician was planning to see in the hospital that day. Unbeknownst to the physician, the MA was not scheduled to work that day. Fortunately, the MA had her phone with her and called the office to ask a coworker to contact the physician with the lab results. Neither the doctor nor the MA had text messaging encryption.

- A doctor asked a staff member to take a picture of the most recent progress note from a treating specialist and to text the picture of the specialist's report to the doctor's unencrypted phone.

- An office manager routinely scans patient EOBs and then texts the scanned information, unencrypted, to the outside biller.

- Doctors and staff frequently text with patients about appointments, medical conditions, and medication questions and think they are HIPAA compliant as long as the patient chooses this mode of communication, despite being unencrypted.

Over the last few years, more medical professionals have come to rely on their personal mobile devices to support their workflows. However, because so many healthcare professionals are using mobile devices, there is a considerable risk that PHI may be accessed by unauthorized people. This occurs because most apps and mobile devices do not require a log-in or log-out and, therefore, if the device is lost or stolen, the PHI stored in the device would be easily accessed and released to unauthorized individuals.

So, while it's perfectly acceptable for staff to use an unencrypted texting service for messages such as, *"Doctor, you have patients waiting,"* a text that includes a patient's protected health information, *"Mary Smith's INR is 7,"* would be considered a HIPAA violation.

The bottom line? If you're texting your office staff, your colleague, the hospital nurses, sending photos, films, videos, reports, or communicating *any PHI relating to a specific patient's care*—**encrypt!** Understand that attempts to circumvent encryption by masking the identity of a

patient (using abbreviations or referring to a patient by location) can easily backfire and result in adverse events caused by patient misidentification. Also, physicians in private practice should understand that if their policy is to utilize unencrypted text messaging for practice management purposes only, there must be adequate education and training of staff to reinforce permissible versus impermissible texting content.

The Joint Commission has made several attempts to adopt a policy that will ensure a safe implementation of text messaging in healthcare. The Joint Commission is encouraging healthcare providers to develop policies and educate staff on the limitations of unsecure texting in the workplace. These might include:

- An inventory of all mobile devices used for texting electronic protected health information (ePHI) (whether provider-owned or personal)
- Proper sanitization of mobile devices that text ePHI upon retirement of the device
- Policies that prohibit or limit the type of information that can be shared via text
- Training on the appropriate use of work-related texting
- Password protection and encryption for mobile devices that create, receive, or maintain text messages with ePHI. 🔒

How to Safeguard Your Practice When Texting



*Joseph Wager, MS, RCP,
Senior Risk Manager, CAP*

Are you violating HIPAA when texting? Consider the following 10 steps to safeguard your practice:

1

Enable encryption on your mobile device.

2

Have a texting policy that outlines the acceptable types of text communications and specifies situations when a phone call is warranted.

3

Report to the practice's privacy officer any incidents of lost devices or data breaches.

4

Install auto-lock and remote wiping programs to prevent lost devices from becoming data breaches.

5

Know your recipient, and double check the "To" field to prevent sending confidential information to the wrong person.

6

Avoid identifying patient details in texts.

7

Assume that your text can be viewed by anyone in close proximity to you.

8

Ensure the metadata retention policy of the device is consistent with the medical record retention policy and/or that it is in accordance with a legal preservation order

9

Ensure that your system has a secure method to verify provider authorization.

10

When conducting your HIPAA risk analysis, include text message content and capability

If you would like more information on how to protect your practice and not violate HIPAA Privacy and Security rules, visit the CAP website: www.capphysicians.com/risk-management/tools-and-resources

May Medical Assistants Call in New Prescriptions or Refills to a Pharmacy?

Amy McLain, BSN, RN
Senior Risk Manager, CAP



It depends... The Medical Board of California (MBC) cautions, “Physicians should view carefully his or her decision to allow medical assistants to perform this task.” It is not the physical act of picking up a phone and dialing a number that is of concern. Rather, “the authority to prescribe or refill prescriptions is only granted to licensed physicians and surgeons, podiatrists, or those individuals authorized by law to do so.” Medical assistants do not have the medical and pharmacological training, the licensure, or the legal authority to evaluate the appropriateness of a medication prescription or refill. Therefore, medical assistants may NOT call in new prescriptions or any medication refills that have changes.

The good news is that California law authorizes medical assistants to “perform basic administrative, clerical, and technical supportive services.” The MBC interprets this law to allow a medical assistant—under the direct supervision of a physician—to call, email, or fax in routine (Schedule 1) medication refills that are “exact and have no changes in dosage level.”

To be compliant with California law and to ensure patient safety, CAP recommends:

1. The supervising physician provide a policy and procedure to be followed by a medical assistant in transmitting a prescription refill to the pharmacy.
2. The medical assistant has training and demonstrates competence in performing the task of transmitting prescription refills to the pharmacy.
3. The supervising physician must authorize the medical assistant to transmit a prescription refill to the pharmacy by writing a patient-specific order or a standing order in the patient’s medical record.
4. The medical assistant documents the medication refill in the patient’s medical record, including their name or initials, the date and time, a description of the task performed, and the name of the physician authorizing the refill. 📌

Sources:

Medical Board of California,
www.mbc.ca.gov

CA Business and Professions Code Section 2069-2071

California Code, Health and Safety Code 1204

CA Code of Regulations Title 16, Article 2, Section 1366-1366.4

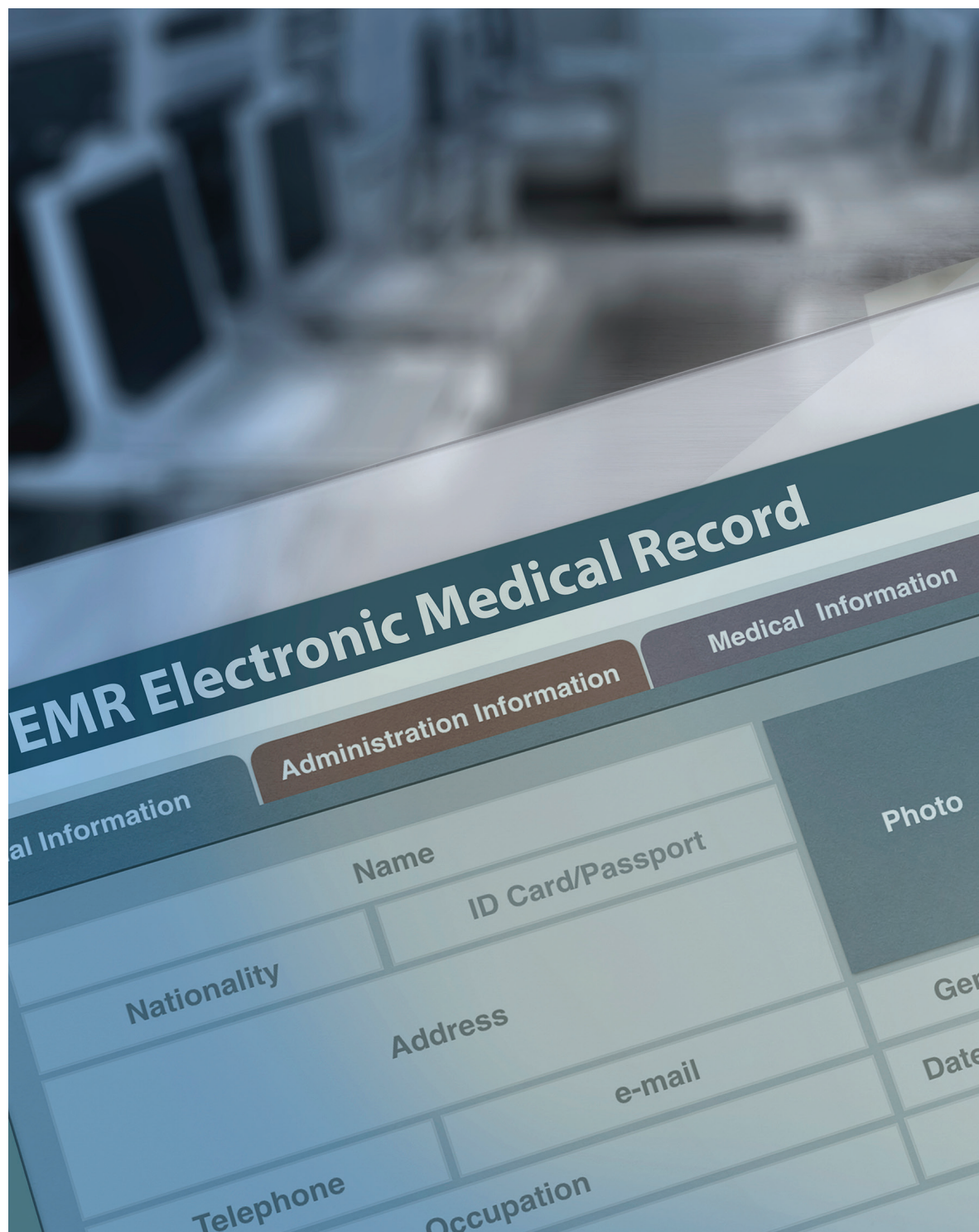
CMA's CA Physicians' Legal Handbook 2018

To learn more about medical assistant scope of practice, visit the Medical Board of California’s website: www.mbc.ca.gov/Licensees/Physicians_and_Surgeons/Medical_Assistants/Medical_Assistants_FAQ.aspx

MEDICINE ON TRIAL

Curbside Consults and EHR

If there is a list somewhere of phrases that will spur disagreement among physicians, certainly “curbside consult” would be included.



Gordon Ownby, JD
General Counsel, CAP



One case study shows how easy access to electronic health records can affect how involved a physician will be perceived in a particular case.

A young mother was on hospital premises with her son, who was being treated for Mast Cell Activation Syndrome. The mother began to experience acute illness and self-injected two doses of epinephrine, which she carried because of her own history of anaphylaxis.

She was then evaluated in the hospital's emergency room, where she injected herself with a third dose of epinephrine. On evaluation, Dr. ED, the emergency department physician, noted the patient's history of recurrent unilateral vision loss and a tightening throat. Dr. ED's initial impression was that the patient's extreme agitation was not consistent with anaphylaxis.

Dr. ED contacted Dr. N, the neurologist on stroke call that day. Dr. ED and Dr. N discussed the patient's condition and at one point, Dr. ED asked Dr. N whether she should call a "code stroke" for the patient. Dr. N recommended instead that Dr. ED obtain a brain MRI, which Dr. ED ordered STAT. Dr. ED evaluated the patient again at 6:30 p.m. and noted the patient was more altered, had bitten her tongue, and would need sedation for the upcoming MRI. Though the MRI was

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degraded by significant patient movement, the radiologist interpreted the study as negative for stroke. Dr. ED admitted the patient to the ICU at 9:30 p.m.

The patient continued to deteriorate and required intubation overnight. A lumbar puncture and an EEG on the patient's second day were inconclusive, and another brain MRI was undertaken on day three. That scan revealed the young woman had suffered an acute infarction of the pons and thalamus. As a result, the patient suffered "locked-in syndrome."

The patient and her husband sued the hospital and numerous physicians involved in her care over those first three days.

One issue of the multi-faceted litigation was the extent of Dr. N's responsibility to the patient. Though he was the neurologist on call, Dr. N did not consider his discussion with Dr. ED as making him part of the patient's "care team," as he was not called in to see the patient and no stroke code was called prior to his call responsibilities ending at 7 p.m.

Under these circumstances, a motion for summary judgment seeking Dr. N's dismissal from the suit would have had significant merit except for activity found in the patient's electronic health records.


During the discovery phase of the litigation, the plaintiffs' attorney deposed individuals at the hospital with the most knowledge of the patient's medical records. That testimony identified Dr. N as logging in to the patient's EHR not only around the time of his telephone call with Dr. ED, but

then again before midnight that evening. Those logs suggested access to the MRI and to the clinical notes, which by that time documented the patient's continued deterioration.

Though Dr. ED testified that at the time of her discussion with Dr. N she considered him as part of the patient's care team, there was no evidence Dr. N took any further action or was involved with the patient—other than those EHR logs. With the plaintiff contending that excessive movement rendered the first MRI non-diagnostic, testimony pointing to Dr. N accessing the MRI would put him squarely in the middle of an argument that more should have been done for the patient that first evening.

Dr. N informally resolved the litigation with the plaintiffs, as did several other providers.

With EHR "metadata" able to show virtually every kind of activity involving a medical record, a physician accessing records while claiming no duty will be faced with a difficult question: If the individual is not a patient, what is the justification for reviewing that person's confidential medical chart?

And while the question of what constitutes a "curbside consult" may be forever debated, electronic proof of a physician's later review of the medical chart could very well knock the physician off the curb and into the traffic. 

HOT BUTTON ISSUE

Kimberly Danebrock, JD, RN, CPPS
Director of Risk Management, CAPAssurance



Medical Cannabis: Know the Latest

Many physicians feel they are not well informed about the indications, risks, benefits, and side effects of medical cannabis. Considering the inconsistency with federal and state laws and the mixed messages between legislation and government action, it is easy to see why most physicians have opted to avoid the issue until the confusion clears. However, as medical cannabis is being accepted and used by more patients, physicians have a responsibility to expand their current knowledge on the topic.

As humans, we all have biases. However, it is vital that bias not interfere with patient care. Physicians should be able to discuss the warnings of using medical cannabis and recognize the side effects. The reality is, although the stereotypical “stoner” will likely always exist, individuals between the

ages of 55 to 65 are the fastest growing demographic starting to use medical cannabis. Technology allows for patients to have access to more information and many individuals are now using medical cannabis for wellness—not to get high. In other words, lumping all cannabis patients together is a disservice to your patients and their care.

While cannabis contains at least 113 cannabinoids, there is only one that gets you high, tetrahydrocannabinol (THC). Because THC is the psychoactive component in cannabis, patients that use cannabis products with THC may exhibit different and more severe side effects than those individuals using cannabis products without THC.

In contrast, cannabidiol (CBD) is the primary non-psychoactive cannabinoid. Often,

continued

cannabis products contain a combination of THC and CBD. However, for wellness, many are choosing products that are solely CBD. Therefore, patients using these products are likely to have minimal to no side effects and they are not getting high.

Under the Federal Controlled Substances Act of 1970, cannabis is classified as a Schedule I drug—which means it has a high potential for abuse, there is a lack of accepted safety, and there is no medically accepted use in the United States.

Therefore, physicians who intentionally make certain oral or written statements, or take other actions, for the purpose of assisting patients to obtain cannabis in violation of federal law, may be subject to serious liability. Even in states that have legalized the medical use of cannabis, such as California, providers are subject to federal law prohibiting physicians from recommending it to patients.

The Ninth Circuit in 2002 ruled (Conant) that physicians have a right to discuss medical cannabis with their patients under the First Amendment as long as they are not aiding and abetting their patients to violate federal drug laws. Therefore, physicians should be cautious if advising patients on medical cannabis. This prohibition should aim the physician away from advising patients as to where they can purchase cannabis and from discussing dispensary options or dosing of products. It is wiser to refer patients to the Internet so they can conduct their own research.

The current recommendations may change in the near future as more research continues, professional organizations recommend the rescheduling of cannabis,

patients increasingly demand access to the product, and the recent FDA-approval of Epidiolex, the first plant-based cannabis (CBD only) pharmaceutical in the U.S. in approximately 80 years. However, at least for now, the uncertainty continues. The FDA-approval of Epidiolex does not make all forms of cannabis legal. Each potential cannabis medication would have to go through the same process and become FDA-approved for physicians to prescribe the drug without fear of violating federal drug laws.

Patients who admit to using cannabis should be provided the warnings listed below and all warnings given should be well documented in the medical record:

- Keep cannabis secure and away from children
- If using products with THC, warn against driving under the influence
- Warn high-risk patients, such as minors, those with kidney and liver disease, women who are pregnant or breastfeeding, and those with certain psychiatric diagnoses, that they may be at higher risk for side effects and other complications
- The potential dangers from long-term smoking for those who partake in that manner
- Advise patients to avoid synthetic cannabis products—these can be dangerous, even deadly

In addition to the warnings listed above, patients should be told of the possible side effects of using cannabis.

The majority of side effects are associated with products that contain THC. Side effects associated with cannabis use include:



- | **Cannabinoid hyperemesis syndrome**
- | **Tachycardia**
- | **Hallucinations, paranoia, anxiety, depression**
- | **Dizziness, decreased balance, coordination, and reaction time**
- | **Hypotension**
- | **Dry mouth, red eyes, hunger**

Until the path on medical cannabis becomes clearer, we encourage physicians to continue to enhance their knowledge on this commonly used drug. Since violating federal law could subject a physician to sanctions, it is vital you understand the rules. Please follow the guidelines provided by the Department of Justice, state medical board, and professional organizations. The following resources can assist you in learning more about medical cannabis:

- Stay up to date with federal law by looking at the DOJ's website at www.justice.gov
- Review CMA guidelines at www.cmanet.org
- The California Medical Board's statement on the medical use of cannabis can be found at www.mbc.ca.gov/Publications/guidelines_cannabis_recommendation.pdf

■ Stay on top of current research by reviewing the Center for Medicinal Cannabis Research at UCSD at www.cmcr.ucsd.edu

■ Review and warn your patients against the use of synthetic products www.cdc.gov/mmwr/volumes/67/wr/mm6720a5.htm

Members of the Cooperative of American Physicians should be aware that under the terms of the Mutual Protection Trust Agreement, members will not be covered for claims arising out of the prescription, use, or administration of medications that are not FDA-approved. ©

Dear Cappy

ADVICE COLUMN

HR Matters

Dear Cappy,

I run a small practice with two other doctors and we're looking to hire a new receptionist. The good news is that we have a few job interviews lined up with several candidates. The bad news is that I'm in charge of the interviewing process. I have no clue about what questions to ask. Are there questions that I should avoid?

Dr. HR Clueless

**Dear Dr.
HR Clueless,**

HR matters can be tricky and they don't teach the particulars of hiring and firing in medical school. Attracting and retaining the right employee . . . asking the right interview questions . . . these are just a few of the many issues that solo or smaller practice physicians encounter on a daily basis.

In California, did you know that there are illegal and inappropriate questions to ask during a job interview? For example, it is now illegal to ask about a job applicant's salary history. And you can't ask about an applicant's criminal background.

It sounds like you need *Hiring Great Staff (And Knowing When and How to Let Go)*, produced by the Cooperative of American Physicians' human resources team. This handy guide will walk you through the job interview process and teach you the difference between legal and illegal interview questions based on the latest California laws. Simply request a free copy at CAPphysicians.com/HRPThelp.

Cappy

**READY TO
LEARN
MORE?**

**Request your free
handbook, *Hiring Great
Staff (And Knowing When
and How to Let Go)*.**

www.CAPphysicians.com/HRPThelp



Dogs in the Office

Dear Cappy,

What do you do when a patient comes into your office with a dog? Tell the patient to leave? Allow the dog in no matter what? I love animals but I want to make sure that my office has a consistent policy on service dogs.

Dr. Dolittle

Dear Dr. Dolittle,

Service dogs are governed by the Americans with Disabilities Act (ADA), the California Disabled Persons Act (CDPA), the Unruh Civil Rights Act, and the Fair Employment and Housing Act (FEHA). A service dog is defined as a dog trained to help an individual with a task that is related to his/her disability. Disabled persons have a right to bring trained service dogs to all public places, including a medical office.

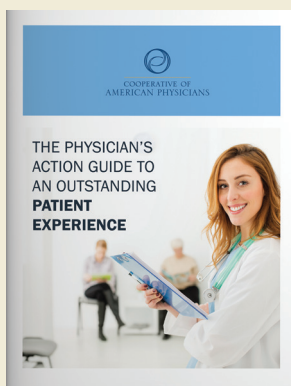
An “emotional support animal” does not perform a specific task. It is an animal that provides the owner with a sense of calm, well-being, or safety. Neither California nor federal law provides protections for emotional support animals or pets and do not require that they be allowed in your office; it is up to your discretion.

The first step is to determine whether the dog is a service dog by asking, “Is your dog a service dog?” If yes, then you can ask what task the dog is trained to perform (i.e., fetch dropped items). Objectively document the answers in the patient’s records (“patient presented with service dog, stated it is trained to pick up dropped items”). You are only allowed to ask whether the dog is a service dog and what task it performs.

If other patients are allergic to dogs, then reasonable isolation precautions must be taken to accommodate everyone. You cannot exclude a service dog because another patient has a dog allergy.

In no event should dogs be allowed in sterile settings such as operating rooms because of the risk of infection. Signage notifying patients is recommended. Always make sure that your office practices are consistent with signage and policy, as well as uniformly applied.

Cappy



Get your free copy, *The Physician's Action Guide to an Outstanding Patient Experience.*

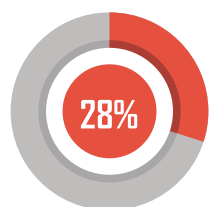
www.CAPphysicians.com/PEPT2

THE OFFICE

10 Ways to Implement a Social Media Policy at Your Medical Practice

Kimberly Danebrock, JD, RN, CPPS
Director of Risk Management, CAPAssurance

Social Media represents



of all online activity



Recent studies show the average user spends 1.72 hours per day on social media, which represents about 28 percent of all online activity.¹ With that much time spent on social media sites, it's important for every large group practice to have a smart social media policy in place.

There are many uses for social media in one's practice, from notifying patients that flu shots are available to sharing health-focused articles. Having well-educated patients means improved compliance, which leads to better outcomes. In addition, social media can be utilized to promote your practice and save money on advertising.

However, there are also risks related to social media that are unique to healthcare. Everyone in a large practice needs to take care to protect patient protected health information (PHI), as unauthorized disclosure of PHI subjects the practice to large fines for violating federal and state privacy laws, civil lawsuits, and possible medical board action.

Here are some steps to ensure that your medical practice is using social media effectively and responsibly:

1. Put the right people in place.

A large practice may have a social media director, but sometimes someone from corporate communications or marketing leads this discipline.

Given the importance of social media, do you have the right team in place? Are they sufficiently experienced and responsible to handle the job? Are they stretched too thin to be effective?

2. Benchmark your social media policy against others.

If your team already has a social media policy, it's a good idea to compare it against others in the industry. Many firms publish their social media policies openly online. Have someone in your office perform an online search of social media policies for healthcare companies and implement the best practices.

3. What makes a good social media policy?

A good social media policy should:

- Define what social media is and how people should use it
- Explain the rules surrounding patient privacy

- Educate staff about the consequences for breaching patient privacy
- Emphasize keeping a workplace with a good business reputation: on social media you not only represent yourself, you represent the practice and the entire medical community
- Explain the importance of professional boundaries.
- Provide clear and multiple examples of ‘what to do’ and ‘what not to do’

4. Creating or revising your social media policy? Choose the right tone.

Some social media policies are dense legal documents: long, detailed, and very complex. Others are brief, and strive to provide easy-to-remember guidelines. Which tone you choose depends on the culture of your organization. It’s important to reflect the language and sensibility of your organization and how you want to represent it.

No matter what the tone is, remember that your policy will only be effective if your staff can understand and remember it.

For example:

- It’s easy to remember: “No photos or videos inside our practice, ever.”
- It’s hard to remember: “Employees who carry smartphones or other devices which contain cameras or other recording equipment must exercise proper judgment about whether a photograph or video might inadvertently lead to a breach of patient confidentiality.”

In brief: keep things as simple and to the point as you can.

5. Instruct staff on the consequences of noncompliance of the social media policy.

Don’t assume your staff is aware of all the regulations about patient privacy and the consequences of a privacy breach. Staff should be educated on the cost of potential fines, civil suits, and medical board investigations. The social media policy should also include what action will be taken against employees who violate the policy, including termination.

The Health Insurance Portability and Accountability Act (HIPAA) has a list of 18 identifiers that are classified as Protected Health Information, including “Any other unique identifying number, characteristic, or code.” A photo of a knife or gunshot wound could easily constitute a breach. Even a picture of an X-ray, with the patient’s name blocked out, might be a violation. In 2011, an emergency room physician who posted a few notable cases she had seen in the ER on Facebook, carefully avoided using patient names or ages. Yet, “unauthorized third parties” were able to determine one patient’s identity from the post, so she lost her hospital privileges, and the Rhode Island medical board found her guilty of unprofessional conduct and fined her \$500.²

6. Beware: Every picture tells a story.

Most people know you should never post a patient’s name, date of birth, or Social Security number online, but few realize how much information can be contained in what seems to be an innocent photograph.

Imagine a birthday party in a hospital emergency room. A colleague snaps a

continued

photo of the birthday girl posing with her friends around the cake. It's posted on Facebook and Instagram. Sounds harmless, doesn't it? But wait, there's a long list of patients written in big letters on the wall behind them, captured in high resolution. Whoops. That's a problem.

Should you ban taking photos at work? Probably.

7. Keep personal and professional social media separate.

Social media breeds a certain informality that's not appropriate for healthcare. If you have a personal Facebook page, it's best not to "friend" any patients.

Insist that professional and personal profiles remain separate. Setting up a professional "business" Facebook page is one option to avoid blurring the lines and maintain smart boundaries: work is work, and friends are friends.

8. Celebrate and teach your natural "internal champions."

Every healthcare organization has staff members who are naturally great at promoting what your large practice does on social media. It pays to get to know them. It is important to work with and train employees on how to share content so people see what your practice has to offer.

Nothing beats authenticity in social media. When you find internal champions who are genuinely excited about what the medical practice is doing, help them do it in the best and safest way possible. The networking and brand awareness benefits for your practice can be priceless.


9. In a large practice, cultural norms matter.

A reality of running a large practice is that you can't monitor 500 employees the same way you can in a small practice of five employees. You have to teach cultural norms about social media, so the staff can have the common goal to protect patient privacy. For example, imagine an enthusiastic young employee is about to take a photo of a patient and her new baby on his smartphone. You need to be able to count on the more experienced employees to stop him and point out the dangers.

10. Guard against too much screen time.

In some healthcare organizations, the interview process includes questions about the prospective hire's social media practices.

The reason is simple: constant distractions impact productivity and patient safety. And because online activities are time-stamped, that information can be used in a lawsuit. If a physician has a bad outcome or caused harm by being excessively online during surgery, it could present problems in the practice's and physician's defense.

A strong social media policy for your large practice can help you guard against potential risks, while maximizing your opportunity to promote your practice and patient health. With good management in place, you can move ahead and maintain social media sites with confidence. 

Sources:

¹www.adweek.com/socialtimes/time-spent-online

²www.databreaches.net/rhode-island-board-disciplines-doctor-after-facebook-description-of-case-results-in-patient-being-recognized

Is Your Worker an Independent Contractor or an Employee?

Margaret Lee Covey, JD
Senior Counsel, CAP

On April 30, 2018, the California Supreme Court issued a decision entitled *Dynamex Operations West, Inc. v. The Superior Court of Los Angeles County* (Charles Lee), which evaluated whether workers in California should be classified as employees or as independent contractors for purposes of California wage orders.

The California Supreme Court decided that all such workers are employees unless:

1	The worker is free from the control and direction of the hiring entity in the performance of the work, both pursuant to contract and in fact; <i>and</i>
2	The worker performs work that is outside the usual course of the hiring entity's business; <i>and</i>
3	The worker is customarily engaged in an independently established trade, occupation, or business.

The California Supreme Court concluded the failure to prove any one of the foregoing prerequisites was sufficient to establish that the worker is an included employee rather than an excluded independent contractor.

Members employing independent contractors who don't meet these criteria may face legal and financial risk when such workers should more properly be classified as employees.

CAP can help our physician members with the following:

- Obtaining affordable workers' compensation insurance
- Answering your questions about HR issues
- Providing coverage for your potential liability for the acts, errors, or omissions of your worker [e](#)

Closing Your Medical Practice

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Closing a medical practice, whether due to retirement, sale, moving, handling of an estate or other reason, can seem like a daunting task. It is not something we are specifically trained to do, it is usually a once-in-a-career occurrence, and there are many steps to take. CAP's Risk Management and Patient Safety Department has provided the following guidelines to assist you through the process.

Closing Your Practice Checklist

Put together your legal and financial team, as the closure of a practice requires legal and financial advice. Early retention of an attorney and an accountant is like the old adage, "an ounce of prevention is worth a pound of cure."

Attorneys are responsible for handling legal issues that can become far bigger problems later, some of which you may not even be aware.

Similarly, accountants will look at financial issues, possibly saving you a lot of money. There are tax implications and financial obligations associated with the closure or transfer of a practice. If it can be prevented, you do not want to receive a bill for something months or years down the road that you did not consider to be your responsibility during the closure of your practice.

Patient Notification

You need to let patients know that you are closing your practice to give them time

to find another provider, obtain copies of their records, and assist with the transfer of care. You should also include a record release if a patient wants a copy of his or her medical record and/or an authorization for transfer of medical records to a new provider. Be sure to notify patients where your records will be maintained.

Patients with differing levels of acuity should receive appropriate notification. For high risk/acuity patients, those undergoing aggressive treatment, and/or those on your follow-up schedule, send notification via certified mail with return receipt requested, and via regular U.S. Mail.

Record Retention

Even after closing a practice, physicians are responsible for patient record retention. For adults, records must be held for a period of at least 10 years after the last date of treatment. For minors, patient records must be held at least 10 years or until the patient is 19 years of age, whichever is longer. If you are closing your practice, you need to research record retention companies. If you are selling your practice, the purchasing physician will generally be the person responsible for retaining your records.

Remember, your patient records are your records. Patients are entitled to copies of their records for the price of allowable copying charges. Never give patients your original records. Without the originals, you cannot verify the care and treatment you provided and/or a patient can improperly modify the records. 🌐

Sources:

The American Academy of Family Practitioners has a comprehensive checklist available for download from their website www.aafp.org/home.html. This checklist is applicable to most types of practice, not just family practices. **The California Medical Association** also has an informative booklet you can purchase, *Closing a Medical Practice*.

Should You Purchase a Practice or Start from Scratch?

Benefits of Purchasing an Existing Practice

- Established patient base
- Current staff is likely to stay on
- Medical and office equipment in place
- Location is acceptable to existing patients
- Computer system and patient history are in place
- Reduced stress and fewer unknowns in the early stages, since everything is already established

Benefits of Starting from Scratch

- New furniture and exam rooms
- May be more conveniently located to your residence
- Lessor might allocate funding for remodel
- Possible preferred location for patients
- Often less costly than purchasing an existing practice

Once you've mulled over the idea of opening your own practice (by now, you've probably done a lot of mulling), and have made the commitment, you want to start off on the right foot. The long-term success of your business heavily depends on what you do in the early planning stages—before you dive into the logistics.

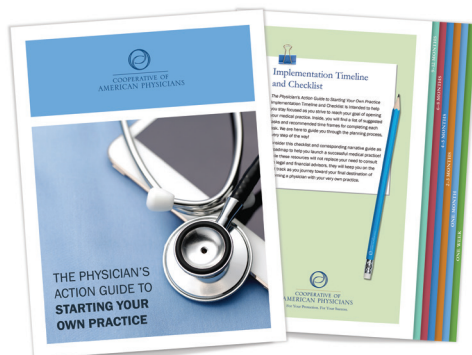
If you haven't already done so, you'll need to decide early on whether you want to open a new practice from the ground up or acquire a practice from a physician in your specialty who may be retiring, relocating, or closing shop for other reasons (which you should ascertain). This decision will inform most other decisions throughout the planning process.

The upside of starting your practice from scratch is building a business and patient base to your exact specifications. The downside is . . . starting from scratch.

If you're planning to acquire an existing practice, search the community for physicians in your specialty who might be retiring or relocating to another city or part of the country (to help retain patients). You'll want to reach out to:

- State and county medical societies
- Specialty associations
- Hospitals in your targeted area


Exercise due diligence to ensure that the outgoing physician's philosophical approach to medicine meshes with your own, and the patients you'll be acquiring fit your desired patient profile. Finally, make sure that the purchase contract is inclusive of everything you want from the practice—and that it is in writing. A good attorney on your start-up team will certainly come in handy! 📞



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

www.CAPphysicians.com/syopt2 or
800-356-5672.

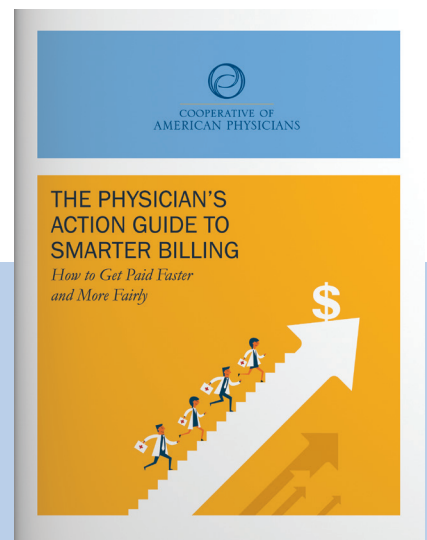
Gabriela Villanueva
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It is too soon to tell whether Governor Newsom, with a large Democratic majority in the Legislature, will move in earnest to overhaul healthcare in California. In any event, the topic is likely to be a priority on the agenda for discussion in Sacramento. 

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