



A Harrowing Ordeal. A Remarkable Rebirth. An Exciting Renaissance.

Dr. Shazia Hyder transformed her health crisis into new insights for her new practice.

In May of 2015, Dr. Shazia Hyder was planning a vacation from her job at the Veterans Administration.

It did not turn out as she expected.

"Before I left, I saw my primary care doctor to get a screening mammogram, all the usual things you do after you've turned 40," Dr. Hyder explains. But she soon received a call at home. Something was very abnormal in the mammogram. Three tests later, it was clear she had Stage 2B breast cancer. It had already spread to her lymph nodes.

"I did some research and chose Dr. Nagaraj as my oncologist, and Dr. Kristi Funk to do the double mastectomy. I have a lot of respect for her. Kristi quietly does a lot of charity work for women who have no insurance or minimal coverage," Dr. Hyder explains.

When Dr. Hyder started chemotherapy that June, she assured her colleagues that she would continue working. "I had no idea that chemo is like a roller coaster. The first day was okay, the second day was tough, and by the third day I was rushing downhill," Dr. Hyder recalls. "It was hard to speak, stand, or walk. I never went back to the VA after that. I had six rounds of chemo, lost all my hair, eyebrows, eyelashes, everything. I looked like a porcelain doll."

In October, Dr. Hyder had a bilateral mastectomy with reconstruction. But things went from bad to worse. "A week after surgery, the right side of my skin started to die — skin ischemia and necrosis. My plastic surgeon said I'd need hyperbaric chamber treatments twice a day." It was another lesson in how difficult and frustrating it can be to be a patient.

"Every day, I felt terrible. I was in pain, couldn't move my arms. My husband, Noushad, was so supportive. He had to dress me, drive me to my sessions, and walk me to the tiny chamber where I'd be trapped for two hours. Did I mention that I'm claustrophobic? The only way to cope was to watch movies. I watched *a lot* of movies," Dr. Hyder laughs.

The hyperbaric treatments literally saved her skin. But there was more work ahead. "When my cancer was removed, there was still some in the two lymph nodes of my left armpit. I had to go back for 25 radiation sessions — so many that the valet soon knew me by name!"

Continued on page 2

DR. SHAZIA HYDER AT-A-GLANCE

Medical Specialty: Internal Medicine

Practice Location: Redlands, CA

Years in Practice: 20

CAP Member Since: 2016

Continued from page 1

One Saturday night, Dr. Hyder's husband rushed her to the hospital. Her whole body was shaking, she was vomiting profusely, and had a fever of 103. She was septic. "It was a real low point for me. I felt things couldn't get worse," Dr. Hyder remembers.

But at last, things began to get better.

Her return to health felt like a rebirth, so she has just opened a new clinic, appropriately named Renaissance. "I do what I love. And I remember every lesson I learned from having been a patient," she says.

When she needed malpractice coverage, "I asked a number of people in private practice and everybody said 'CAP is the best,' and they were right. It has been excellent so far."

Dr. Hyder is dedicated to helping women who have breast cancer by sharing all she has learned. "I know what it's like to be uncertain, to have to stay on top of appointments, to be at a loss for what to do next. It was hard to navigate even as a doctor. I want to make it easier." You can find her informative videos on Facebook (search for "Renaissance MD") or YouTube (search for "Shazia Hyder").

"Illness puts life in perspective. What's really important? Your love and your family. My husband, my son Shaan (age 10), and my daughters Samar (13) and Sara Rose (6) are more precious to me than ever. My mom and my sister-in-law live with me and help. I still have pain. But mostly, I feel lucky." ✨

Coming Around the "Block": Proposed Medicaid Reform

In the ongoing "repeal and replace" discussion surrounding the Affordable Care Act (ACA), a constant focus is the topic of block grants to pay for Medicaid (known in California as Medi-Cal). One of the proposals being considered is a renewed use of block grants.

A popular Republican approach that dates back to the Reagan administration, block grants aim to control spending using a budgetary funding mechanism by which full control of the program is turned over to the states with the federal government imposing a cap on what it spends each year. If implemented for the Medicaid component of the ACA, block grants would materially change the structure of the program.

Currently, the federal government covers a fixed *percentage* of a state's Medicaid cost: Fifty percent here in California for the traditional pre-ACA expansion population and up to 90 percent of the cost for those covered under the expansion started in 2013. The state is then responsible for paying the difference and under this current model, states are required to cover certain services and people. Under a block grant model, the

state would receive a fixed dollar amount, with the state (still) responsible for all costs in excess of the capped amount, but essentially with no requirements attached. This leaves the state to decide which services to provide and who will be eligible to receive those services.

The block grant model is a funding mechanism intended to produce budgetary savings by basing the state's initial block grant amount on its current or historical spending and then increasing it annually at a slower rate, such as at the rate of inflation, as opposed to the rate of growth in federal Medicaid spending. This can result in federal funding shortfalls that grow steadily larger each year. The nonpartisan Congressional Budget Office estimates recent block grant proposals could cut Medicaid spending by as much as one-third over the next decade. Such cuts would start small and grow larger over the years, placing an increasing responsibility on states to reallocate resources.

For more background on block granting, see: <http://khn.org/block-grants>. ✨

Are Your Assets Adequately Protected?

When it comes to protecting your personal assets, you deserve the same expert, trustworthy, personalized attention from your insurance broker that you give to your patients. That is why CAP Physicians Insurance Agency has partnered with Integro's Private Client Group as your strategic partner committed to delivering superior service. We are available whenever you need us, and confidentiality is always guaranteed.

Custom Services Designed Exclusively for CAP Physician Members

Significant personal assets require higher levels of protection, often with uncommon coverage requirements not available through standard policies. Because your needs are unique, we work with you to create a plan designed specifically for you. We will review your coverage on an ongoing basis to evaluate potential revisions in response to economic changes, market trends, or changes in your needs.

As a CAP member, you are eligible to receive a variety of personal, traditional, and specialty coverages, including:

- Home and Auto
- Vacation Homes and Rentals
- Fine Art, Jewelry, and Collections (*including wine*)
- Recreational Vehicles
- Yachts and Watercraft
- Private Aircraft
- Gentleman Farming and Wineries
- Personal Umbrella (*provided through CAP's group program*)

Group Personal Umbrella

Most of us do not like to think about the possibility of something bad happening to us or our family, such as an automobile accident, slip and fall, or someone drowning in our pool. But unfortunate events like these can strike at any time and inadequate liability insurance coverage can prove to be financially devastating.

As a physician-owned company, CAP is able to secure exceptionally competitive rates for group personal umbrella insurance coverage through an A+ rated carrier, which sits on top of your homeowners and automobile coverage to help ensure that you have adequate protection.

For example, as a member of CAP, you can purchase a policy that provides \$3 million in excess liability coverage for \$559 per year. Additional limits are available at the same low prices, for up to \$12 million in excess liability coverage. CAP's personal umbrella coverage also includes, at no additional cost, \$1 million in uninsured and underinsured motorist coverage. No underwriting is required. Just complete the enrollment form, pay the premium, and you are covered. It's that easy.

If you would like to learn more about these outstanding coverages, visit the CAP website at www.CAPphysicians.com and click on "Risk Management—Personal" to review coverages and complete an online application. Or, you may call CAP Physicians Insurance Agency at 800-819-0061. ➦



CAP PHYSICIANS INSURANCE®
License No. 0F97719



The Successful Physician

by Carole A. Lambert, MPA, RN

Good Things Come in Small Packages

We live in a world of juxtaposed ideas and options: big box store versus neighborhood store; bigger and better versus small is beautiful; mach speed versus stop and smell the roses; just the highlights versus focus on the details; the forest versus the trees. These contrasting ideas and choices confront CAP members at every turn as they move forward with maintaining their practices and caring for their patients. More than half of all CAP members are part of small group practices, and with them we firmly believe that good things come in small packages. In alliance with CAP members in larger and hospital-based groups, small practices are a vital part of the healthcare delivery continuum and, as Casalino and his colleagues observed, there are lessons that might be learned from them.

What lessons can be learned from small practices? Dr. Danielle Ofri, a physician at Bellevue Hospital and an associate professor at NYU School of Medicine in New York, notes, "Medicine is unquestionably harder than it was 10 years ago. Many more doctors I know talk about quitting (an option that is not equally available to patients)." Bodenheimer and Sinsky in their travels observed, "Society expects more and more of physicians and practices, particularly in primary care." Detsky says, "Patients want their health to be better, to be seen in a timely fashion with empathy, and to enjoy a continuous relationship with a high-quality clinician whom they choose."

The word that occurs frequently and prominently in the literature is "relationship." In a time of change and uncertainty — and when were we ever not going through change and experiencing uncertainty — it may be that relationships are our most reliable reference

points and perhaps even our anchors. Dorr Goold and Lipkin write: "The doctor-patient relationship has been and remains the keystone of care: the medium in which data are gathered, diagnoses and plans are made, compliance is accomplished, and healing, patient activation and support are provided."

Dorr Goold and Lipkin were writing in 1999, but their observations about compliance, healing, activation and support are borne out by contemporary studies: Casalino and colleagues in 2014, and Liaw and colleagues and Squires and Blumenthal in 2016. Casalino and colleagues' study concluded that small practice size was associated with fewer preventable hospitalizations due to stronger relationships among physicians, patients, and staff, and improved continuity. Squires and Blumenthal observed that "many patients and physicians deeply value the personal relationships that smaller settings can cultivate."

However large or small our organizations are, it is the relationships we form and maintain that make small packages full of good things. As physicians care for patients and their families, and work with staff, it becomes ever more clear that "the relationship is part of the treatment program," as Savitsky observed. Our challenge here at CAP is to support our members through times of change and uncertainty as practices small and large, urban and rural, primary care and specialty care, continue their vital work of building relationships among patients, families, physicians, and staff that will be deeply rewarding to all involved. ➦

Carole Lambert is Vice President, Practice Optimization for CAP. Questions or comments related to this article may be sent to clambert@CAPphysicians.com.

Case of the Month

by Gordon Ownby



Court Rejects Therapists' Challenge to Mandatory Reporting of Illegal Online Viewing

California's statutory requirement that a healthcare provider report to law enforcement or child welfare agencies when patients disclose that they have viewed child pornography online is constitutional, the Court of Appeal has ruled.

The ruling thwarts a challenge by a certified alcohol and drug counselor and two licensed marriage and family therapists who claimed that a 2014 revision to the state's Child Abuse and Neglect Reporting Act (CANRA) violates their patients' constitutional right to privacy.

In their attempt to bar enforcement of California Penal Code Section, 11164 et seq., the therapists claimed that their patients, including those in treatment for sexual addiction and sexual attraction to children and those who admit downloading and viewing child pornography, do not "present a serious danger" to others and that mandatory reporting will interfere with needed treatment.

"These patients typically have no prior criminal record or history of 'hands-on' sexual abuse of children, no access to children in their home or employment . . . and often express disgust or shame about their sexual attraction to children for which they are actively and voluntarily seeking psychotherapy treatment."

The therapists argued that the 2014 amendment to CANRA adding a healthcare provider's knowledge of an individual's accessing child pornography through digital media to the statute's reporting requirements does not substantially further state goals because a patient's viewing of child pornography is not evidence that the patient has engaged in "hands-on" abuse or exploitation. Unless stricken, they argued, the new provision will discourage patients from disclosing intimate details needed to provide effective therapy and deter potential patients from seeking treatment at all.

The plaintiffs claimed such mandated reporting of online viewing is "effectively useless" as a tool to identify

and protect children and argued that the privacy rights of psychotherapy patients should prevail.

The trial court rejected the therapists' claim at the pleading stage, a ruling that was upheld by the California Court of Appeal in *Mathews v. Harris*.

The appellate court cited the landmark case *Tarasoff v. Regents* to explain that a patient's right to privacy is not absolute: "The public policy favoring protection of the confidential nature of patient-psychotherapist communications must yield to the extent to which disclosure is essential to avert danger to others. The protective privilege ends where the public peril begins." Enacting and amending CANRA to include Internet child pornography as "sexual exploitation" sufficiently addressed that peril because the legislative action was "reasonably calculated to further the purpose of protecting abused and sexually exploited children."

The court also pointed out that under California case law, there is no right to seek a particular form of medical treatment as a cure for one's illness. "No fundamental privacy interest guarantees treatment for a sexual disorder that causes a patient to indulge in the criminal conduct of viewing Internet child pornography."

And on the question of whether viewing of electronic images of children caused them harm, the Los Angeles-based Court of Appeal was quite emphatic: "The claim that CANRA cannot be expanded to include Internet child pornography victims because they are 'virtual' and therefore, are not harmed is patently absurd."

"The consumption of child pornography is not distinguishable from production and distribution in terms of harm to the victims . . . accordingly, we disagree with plaintiffs that once the images are on the Internet and are therefore 'virtual,' the purposes of CANRA are irrelevant." ➦

Gordon Ownby is general counsel for CAP. Questions or comments related to this article should be directed to gownby@CAPphysicians.com.

Risk Management and Patient Safety News



Is Texting Going to Be Your Friend or Foe When It Comes to HIPAA?

by Sue Jones, BA, LVN, CPHRM

Recently, while in a few physician offices where texting is commonplace between physicians and staff, the question of whether they are following the HIPAA safeguards for texting, most of the time the answer was met with "Sure, we are HIPAA compliant. No worries here."

A little more digging and asking questions proved otherwise. In just a small sample of physician offices visited, the physicians and staff were violating HIPAA privacy and security rules while texting on a daily basis. Not because they were not trying to be HIPAA-compliant, but because they didn't know better.

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

- 1) Doctor texted MA (on MA's personal mobile phone) requesting the MA text the lab results received by the office on a patient the physician was going to see in the hospital that day. Unbeknownst to the physician, the MA was not scheduled to work that day. Thankfully, the MA had her phone with her and called the office to reroute the request to a staff member on duty to call the physician with the lab results. Neither the physician nor the MA had text messaging encryption.
- 2) Doctor asked a staff member to *take a picture* of the most recent progress note received by a treating specialist that was in the patient's chart and text the picture of the specialist's report to the doctor's unencrypted phone.
- 3) NP *took a picture* with her personal mobile phone of a patient's lesion to get the supervising physician's take on the photo and then sent it *unencrypted* to the physician.

- 4) OM routinely scans patient EOBs and texts the scanned information *unencrypted* to the outside biller.
- 5) Doctors frequently think unencrypted texting with their staff about patients is okay since the messages are being sent between office personnel.
- 6) Doctors and staff frequently text with patients about appointments, medical conditions, and medication questions and also think this is okay as long as the patient chooses this mode of communication even though it's unencrypted.

According to HIPAA, in order to protect patient health information (PHI) when using mobile devices for texting purposes, encryption should be used to protect the PHI from unauthorized user access.

HealthIT.gov offers the following guidance when setting up encryption on a mobile device:

How can you encrypt data that are stored on your mobile device?

Encryption methods vary with the device. You will need to research your mobile device's encryption capability. If your mobile device does not come with built-in encryption, you will need to download an encryption application. Research mobile apps before downloading them to your mobile device to verify they are from a trusted source.

Why should you encrypt data sent by your mobile device?

When you encrypt data in motion, you prevent unauthorized virtual access to the data while it is in transit (e.g., accessing an EHR system or lab test results using your mobile device). Consider carefully the risks associated with sending text messages containing protected health information. To improve the protection

Continued on page 7

of information being sent in a text message, consider using secure messaging that is encrypted instead of SMS (Short Message Service), which is not.

For additional security when texting, disable SMS preview on your device. If you do not have SMS preview disabled on your device, then others can view text messages on your device's locked screen without authenticated or authorized access.

How can you encrypt data that are sent by your mobile device?

There are several different ways to encrypt data in

motion, such as a virtual private network (VPN) or a secure browser connection.

As we hear of HIPAA breaches continuing on a daily basis, it is extremely important that medical offices that use texting as a mode of communication within the healthcare organization and with their patients take the steps to ensure the text messages are secure and patient health information is protected. ➦

Sue Jones is a Senior Risk Management and Patient Safety Specialist for CAP. Questions or comments related to this article should be directed to sjones@CAPphysicians.com.

How Online Scheduling Can Help Your Practice

Did you know that 26 percent of patients could fill empty same-day or next-day slots daily if given access to online scheduling? And that you could generate \$1,000 more revenue per week if just two more daily slots are filled?

To help you enhance your online presence and boost business, CAP has partnered with PatientPop to offer you discounted rates on its all-in-one practice growth platform solution. PatientPop can build and optimize your website, automate positive feedback, and enable patients to quickly and easily book appointments online.

CURRENT AVAILABILITY

42%	of patients would like to self-schedule appointments, but only
17%	of patients are able to do so.
34%	of appointments are made after hours.
11%	of appointments are made online.

2019 PROJECTIONS

66%	of healthcare providers will offer online scheduling.
64%	of patients will use online scheduling.
986	million appointments will be made, generating
\$3.2	billion in revenue.

For more information about PatientPop or its online scheduling feature, please contact Jessica Neyer at PatientPop at 818-378-8072 or jessica.neyer@patientpop.com.

For a free assessment of your practice's online visibility and website performance, go to www.patientpop.com/scanner/cap/web.





COOPERATIVE OF
AMERICAN PHYSICIANS

Cooperative of American Physicians, Inc.

333 S. Hope St., 8th Floor
Los Angeles, CA 90071

PRESORTED
STANDARD
US POSTAGE PAID
LOS ANGELES, CA
PERMIT #1831

February 2017

IN THIS ISSUE

- 1 **CAP Member Profile: Dr. Shazia Hyder**
- 2 **Public Policy:**
Coming Around the "Block": Proposed Medicaid Reform
- 3 **CAP Physicians Insurance Agency News:**
Are Your Assets Adequately Protected?
- 4 **The Successful Physician:**
Good Things Come in Small Packages
- 5 **Case of the Month:**
Court Rejects Therapists' Challenge to Mandatory Reporting of Illegal Online Viewing
- 6 **Risk Management and Patient Safety News:**
Is Texting Going to Be Your Friend or Foe When It Comes to HIPAA?
- 7 **How Online Scheduling Can Help Your Practice**

CAPSules® is a publication of the Corporate Communications Department of the Cooperative of American Physicians, Inc.
333 S. Hope St., 8th Floor, Los Angeles, CA 90071 | 800-252-7706 | www.CAPphysicians.com.

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

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