



## The High Cost of HIPAA Breaches

The Health Insurance Portability and Accountability Act (HIPAA) is a framework to aid in the protection of our most sensitive information. It provides guidance for you as a healthcare professional who is responsible for protecting this information.

Failing to comply with HIPAA, even if it's not your fault, results in audits, significant fines, potential legal action from your patients, damage to your reputation, and the possible loss of your business.

### WHAT HAPPENS IF YOU EXPERIENCE A BREACH?

Being randomly selected is one way you can find yourself called for a HIPAA audit, but you also could fall victim to the growing threat of a malicious cyber attack. Although doing everything possible to prevent an attack may not stop one from happening, being prepared if one does happen is critical to survival. If you did get breached, and you did everything reasonably possible to prevent it, here's what you are facing.

In general, fines are broken down into four categories, and each has an annual cap of \$1,500,000. It is important to point out this is per violation. We have seen several fines exceeding the annual per violation cap of \$1,500,000. And we will probably see more.

#### Category 1

While "I didn't know" is not an excuse to avoid following HIPAA laws, there is a category for this in the penalty phase of an audit. If a breach occurred and you didn't know it – and you reasonably may not have known of the violation – then you could fall into this category. You still need to demonstrate that you met all of the HIPAA requirements (like a regular HIPAA risk



assessment, for example) and were otherwise in compliance. The per-record penalty structure can range between \$100 to \$50,000, assessed solely at the discretion of the U.S. Office for Civil Rights (OCR).

#### Category 2

This category addresses reasonable cause, where you knew, or would have known by exercising reasonable diligence, that the act or omission was a violation. In this case, you did not display "willful neglect" and otherwise conducted the necessary steps to remediate the breach. Fines in this category are from \$1,000 to \$50,000 per record or violation.

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### Category 3

This category introduces the act of “willful neglect” – and the potential for jail time. In this case, the violation was the result of conscious, intentional failure or reckless indifference to meeting the obligations of HIPAA compliance, but the violation was remedied within 30 days of discovery. An example would be sharing PHI over unsecured email with patients as a common practice. Once identified as being in violation, the process was stopped and a secure, encrypted process was implemented. Penalties in this category range between \$10,000 to \$50,000 and possible imprisonment.

### Category 4

Landing in this category has proven to be exceedingly costly. Prison sentences and fines in the millions of dollars have been levied on individuals and organizations for displaying willful neglect and failing to correct the issue. This category includes fines of at least \$50,000 and prison time of up to 10 years.

### HOW HIPAA PROTECTS YOUR PATIENTS

For your patient, a breach is not only the exposure of their most sensitive information, but also the loss of their identity, a process that can take years to remedy.

HIPAA protects patients by affording them specific rights to their information. Patients can designate who can see their records, including which family members. We suggest you have them do this in writing. It is important to get that right – impermissible disclosure fines are far too common. Additionally, HIPAA requires you to make their records available to them. You must provide the patient with his or her records within 15 days in California, shorter than the 30-day time frame called for in HIPAA.

It is your responsibility to keep your staff up to speed on these requirements. Regular, recurrent training is a big step in the right direction.

### THE BOTTOM LINE

Be absolutely certain you’ve done all you can to comply with HIPAA, and if you do have a breach, act quickly and responsibly. You may not be able to avoid a breach, but you can mitigate the damage with proper preparation. ↩

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July 2017



# The Successful Physician

by Carole A. Lambert, MPA, RN

## Quality: The 60 Percent Solution

What is quality? Is it service? Is it amenities? Is it results? In previous issues of *CAPSules*, we have looked at Improvement Activities (IA) and Advancing Care Information (ACI). We have reflected that, while we have always managed to metrics, the continuing evolution of payment reform as evidenced by the Quality Payment Program (QPP) has at times felt like a rockslide bearing down on us. But amid our eye-rolling, hand wringing, and deploying of expletives, we come to see that underlying improvement activities, advancing care information, and quality are our old friends communication and documentation in the many forms they take.

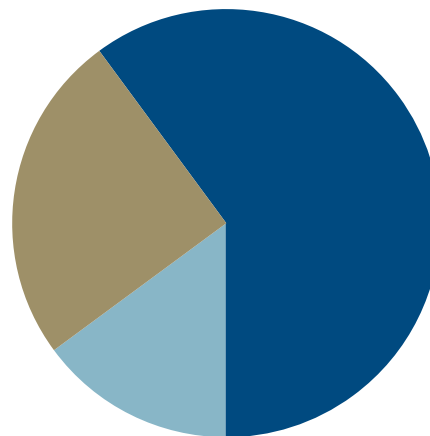
In May, we looked at three high-weighted activities that could contribute the most to your IA score: population management through personalized, periodically reviewed care plans; collection and follow-up on patient experience and satisfaction data with a plan of improvement where indicated; and patient safety and practice assessment, especially with regard to prescribing practices.

In June, we looked at the required measures in ACI: monitoring the safety and security of the electronic health record system; using electronic communications with patients with appropriate safeguards and informed consent; having and using a process for follow-up and follow through to improve patient understanding of their plan of care, improve adherence to the plan, and achieve the desired outcome; and e-prescribing.

This month, we consider quality and the measures that will contribute to that important 60 percent of the MIPS 2017 performance score.

If we persist in our approach of taking credit for what we do best, based on years of practice and thousands of patient/family interactions, we can look at the list of measures and select measures that best fit the practice:

2017 MIPS Performance



- Quality (60%)
- Advancing Care Information (25%)
- Improvement Activities (15%)

six measures, including one outcome measure and one high-priority measure. There are 300 to choose from. We can refine our search by specialty. There are 30 specialty measure sets. Or by high priority or by data submission method.

What follows is a sample list of measures that might reflect activities in a general medical practice. As you read through them, notice how they link up with Improvement Activities and Advancing Care Information. A striking feature of the Quality Payment Program is its acknowledgement of the dynamic relationship among all the components of the comprehensive patient-centered care CAP member physicians and practitioners provide.

**Biopsy follow-up:** Percentage of new patients whose biopsy results have been reviewed and communicated to the primary care/referring physician and patient by the performing physician.

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**Breast cancer screening:** Percentage of women 50 to 74 years of age who had a mammogram to screen for breast cancer.

**Care plan:** Percentage of patients age 65 years and older who have an advance care plan or a surrogate decision maker documented in the medical record or documentation in the medical record that an advance care plan was discussed but the patient did not wish or was not able to name a surrogate decision-maker or provide an advance care plan.

**Closing the referral loop:** Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.

**Hypertension-improvement in blood pressure:** Percentage of patients age 18 to 85 years with a diagnosis of hypertension whose blood pressure improved during the measurement period.

**Controlling high-blood pressure:** Percentage of patients 18 to 85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90mmHg) during the measurement period.

We were recently asked what can providers who are not participating – or are not fully participating in 2017 – do to ensure that they are prepared for 2018?

Our answer: Practitioners should consult with colleagues and take advantage of the free support services available to understand where their practices stand in relation to the reporting structure, measures, and requirements. We are convinced that the gifted and dedicated practitioners in CAP will get organized to demonstrate to themselves, to CMS, and to the wider community just how good they are – and get paid as well!

Watch for updates from CAP as the Quality Payment Program evolves and new information and resources become available. ↩

#### SOURCES

CMS Proposes Quality Payment Program Updates to Increase Flexibility. Health Services Advisory Group, accessed June 21, 2017.

Preparing for MIPS in the Small Group Practice. Impaq International webinar, June 8, 2017.

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## Litigation Education Retreat: Invaluable Support for Members Facing a Malpractice Lawsuit

On Saturday, October 14, 2017, CAP will host its fall Litigation Education Retreat in Orange County to provide guidance and support to physician members currently facing a medical malpractice lawsuit.

This daylong event, facilitated by a PhD, a medical doctor, and malpractice attorneys, is intended to help physicians best prepare for trial and cope with the litigation-related emotional fallout.

We urge members to attend as early in the litigation process as possible to help ensure the best outcome possible at trial. We also encourage you bring your spouse or partner who will support you through this

challenging time. This retreat is included as part of your CAP membership, so there is no charge to you or your guest, and lunch and refreshments will be served.

Members living outside of the Southern California area may be eligible for travel expense reimbursement.

For additional information or to RSVP, please contact Andrea Crum at [LERinfo@CAPphysicians.com](mailto:LERinfo@CAPphysicians.com) or 213-473-8725. CAP, a CME-accredited provider, designates this educational activity for a maximum of six AMA PRA Category 1 Credit(s)<sup>™</sup>. ↩

## CAP Benefits That Save You Time, Money ... and Aggravation

Looking to cut costs on office and medical supplies? Need IT support? Considering financing a new home or office building? Or just want easy access to a plethora of practice management support programs under one roof? Then look no further.

As a CAP member, you can take advantage of the myriad no-cost or discounted practice management programs that leverage the buying power of your nearly 12,000 member-strong cooperative. These programs – all administered by highly reputable, CAP-vetted vendor providers – are designed to boost your bottom line and/or lighten your administrative load. Some even extend beyond your practice and into your home.

You can pick and choose from the following CAPAdvantage programs, based on your individual needs:

### Professional/Financial Programs and Services for Your Practice

- Medical practice financing
- Commercial real estate advisors
- CAP Visa Affinity credit card

### Offerings That Help Save Money, Optimize Productivity, and Meet Regulatory Requirements

- Group purchasing program
- HIPAA-compliance solution
- Online compliance training
- Online reputation management / website development
- Office IT support
- HR/payroll/benefits administration solutions
- CAP Job Board
- Patient Experience Survey Program
- Revenue cycle management/EHR/patient engagement



### Personal Services for You and Your Family

- Residential mortgage services
- Physician specialized financial planning and wealth management
- Pet insurance

If you would like to learn more about any of these CAPAdvantage offerings, please contact Sean O'Brien, Vice President of Membership Programs, at 888-645-7237 or at [CAPAdvantage@CAPphysicians.com](mailto:CAPAdvantage@CAPphysicians.com). He'll be happy to expound on the benefits of each. ➤



## Short-Term and Long-Term Disability Insurance – Guaranteed Coverage!

How long do you think your current savings will cover your household expenses should you become disabled? Years? Months? Weeks? Hours or less? You get the point.

To help make sure that you and your family are financially sound should an illness or accident prevent you from working, your dedicated CAP Physicians Insurance Agency, Inc. is pleased to offer you Short-Term Disability (STD) and Long-Term Disability (LTD) Insurance protection – with coverage guaranteed! The CAP Disability Insurance Program<sup>1</sup> can supplement your current LTD policy or act as stand-alone coverage. You can obtain these coverages with:

- No medical underwriting
- No income documentation

There is a 14-day elimination period before benefits become payable under the STD plan, and the \$1,000 weekly benefit is payable for an 11-week benefit period. It will pay in addition to benefits received from other policies and eligible State Disability benefits.

If you're looking to close the 180-day gap while waiting for the core disability coverage of up to \$2,000 monthly benefit that comes with your CAP membership, you may want to consider the 24-week benefit period option.

When you choose supplemental LTD coverage<sup>2-3</sup>, benefits become payable after the 91st day of disability. You can choose from two monthly benefit options of up to \$10,000 a month or up to a 60-percent maximum of your income. You also can choose from a policy that pays for five years only or to age 65<sup>4</sup>.

To learn more, contact the CAP Agency at [Benefits@CAPphysicians.com](mailto:Benefits@CAPphysicians.com) or 213-576-8530 -- we'll be happy to assist you. You also may get rates or enroll by visiting [www.CAPphysicians.com/benefit](http://www.CAPphysicians.com/benefit).

Take advantage of this opportunity and **enroll now** for these very important coverages! ➦

<sup>1</sup>Must be working at least 17.5 hours per week and not currently disabled; minimum \$200,000 annual income required to qualify for \$10,000 maximum benefit, or benefit will be based on 60 percent of income. Rates are subject to increase after each carrier review period and will change after each birthday that ends in a zero or a five, as you move into a new age band. Limited time pre-existing condition exclusions apply.

<sup>2</sup>Income conditions apply. Please ask for details.

<sup>3</sup>Benefit will offset for eligible State Disability and Social Security Disability benefits.

<sup>4</sup>Coverage and benefits are still available, but for a limited time.



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## Clearing the Smoke from the California Budget

### Public Policy

Every year, the California Legislature is required to pass the state's budget by the constitutional deadline of June 15. The process begins in January, with the Governor releasing his budget proposal indicating appropriation priorities. Negotiations then begin between the Governor, the Legislature, and lobbyists in order to reconcile differences in spending priorities, many times up until the deadline.

A highly contended budget item this year was Gov. Jerry Brown's proposal to re-appropriate funds derived from the tobacco tax increase that voters approved last November with the passage of Prop. 56. It is estimated that the \$2-per-cigarette-pack increase will generate between \$1.3 and \$1.7 billion in new revenue.

In the Governor's January budget proposal, Brown targeted this new revenue to shore up funding for the overall Medi-Cal program, the state's version of federal Medicaid. The proposal immediately became problematic for legislators and the California Medical Association (CMA), as well as the California Dental Association (CDA), both sponsors of Prop. 56, since much of the new revenue was advertised to go toward raising payments to doctors and dentists who treat the state's approximately 14 million Medi-Cal patients. The primary

reason promoted by Prop 56's backers was to help increase provider rates and climb back from a recession-induced 10-percent cut to payments to healthcare providers in 2011. California currently ranks 48th in the country on its reimbursement rates to providers who treat Medi-Cal patients.

Between January and May, both the CMA and CDA engaged in negotiations and budget committee hearings in an attempt to persuade Gov. Brown to designate funds from Prop. 56 to secure higher provider payments. When the Governor's final budget was released in June, it revealed \$325 million in new payments to physicians and \$140 million to dentists. Another \$50 million was to go toward increasing reimbursements to reproductive health providers and \$27 million for higher payments to certain care facilities for the developmentally disabled. This left some \$700 million in Prop. 56 funds for general Medi-Cal costs — a decrease from the Governor's original proposal of \$1.2 billion.

Ultimately, a compromise was reached but this may not be the last word of this issue, considering that current federal proposals to repeal the Affordable Care Act include deep cuts to Medicaid. ↩

# Case of the Month

by Gordon Ownby



## Compelling Reading: Every Section of the Radiologist's Report

When a family practitioner or hospitalist gets back a radiologist's report, it is natural to look first for the findings related to the reason for the patient's referral. But a physician's duty doesn't stop there.

For several years, a middle-aged woman had been treating with her family practitioner, Dr. FP. She was an insulin-dependent diabetic, had history of heart disease, dizziness, hypertension, and knee arthroscopy, and was under further treatment by a pain management specialist for her degenerative disc disease.

In March, paramedics brought the patient to the emergency room after she developed chest pain during physical therapy. Her ER physician's test findings were essentially negative, but for mild pulmonary edema. The ER physician ordered a CT on the brain and admitted the woman under the care of a hospitalist, Dr. H. The patient complained to Dr. H of left-sided numbness, headaches, and chest pain. Dr. H worked the patient up for cardiac issues and requested a neurology examination. She also ordered a CT angiogram to rule out aortic dissection. The radiologist reading the angiogram reported no evidence of an aneurysm, but noted a diffused prominence of the main pancreatic duct, measuring up to 5 mm. The radiologist recommended a dedicated pancreatic protocol, contrast-enhanced study versus ERCP/MRCP, for further evaluation. She transcribed her report and copied Dr. H and Dr. FP, who received the report that same day.

Also, that same day, the neurologist examined the patient, found no acute ischemia, and noted that the patient's symptoms of severe headache and chest pain had resolved. An MRI of the brain showed no infarct and the neurologist considered the patient to have had a transient ischemic attack. The next day, Dr. H "updated Dr. FP" that the patient's cardiac enzymes were normal and that she complained of scattered numbness in the left arm and chest. A cardiology consultation ordered

by Dr. H was largely normal and Dr. H discharged the patient home on day three.

The patient followed up with Dr. FP two days post discharge, but his chart reflected no discussion of the CT angiogram report. The patient's visits with Dr. FP into the next year were for low-back and joint pain until December of that year, when she complained of pain and tenderness of the abdomen. Dr. FP ordered an abdominal and pelvic CT, which revealed a 20x16 mm mass in the neck of the pancreas as well as lymph node enlargement. A follow-up biopsy led to cytologic diagnosis of pancreatic adenocarcinoma.

Dr. FP continued to care for the patient during her chemotherapy. Late in the year of that treatment, a liver biopsy revealed cirrhosis. After a hospice stay, the patient died at home.

Overall, the record of this patient revealed a thorough workup of the patient's cardiac and nervous system but no investigation into the radiologist's recommendation on her observations concerning the patient's pancreas.

The patient's husband and three adult children sued Dr. FP for medical negligence, alleging that the wife and mother was discharged from the hospital three years before her death with no knowledge of the pancreatic findings. In his deposition, Dr. FP offered no explanation for not discussing those findings with the patient.

Though Dr. FP prevailed at trial, his defense was based on a "causation" theory. That is, even had the patient's pancreatic findings been worked up immediately, her cancer was of the type that intervention would not likely have saved her.

It was a trial that may have been avoided had the patient's healthcare team addressed even those parts of the radiologist's report that departed from what it was looking for. ⚡

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## Scribes: Ways to Enhance the Practice Experience, Increase Productivity, and Reduce Risk

by Ann Whitehead, RN, JD

As physicians attempt to identify ways to reduce the clerical load associated with electronic health records (EHR) data entry, they are increasingly turning to medical scribes. Research in many medical specialties has shown that the addition of medical scribes to the clinical team enhances physicians' practice experience and increases productivity. Scribes are now the fastest growing medical field. Estimates published in *The Journal of the American Medical Association* suggest that the number of scribes will grow almost five-fold by 2020 to over 100,000, with one scribe for every nine physicians.

In the *Journal of American Board Family Medicine*, a study concluded, "In an outpatient family medicine clinic, the use of scribes substantially improved physicians' efficiency, job satisfaction, and productivity without negatively impacting the patient experience." The study noted that the physicians in the practice spent an average of 5.1 fewer hours per week on documentation, and the annualized projected return was more than double the salary cost for two scribes.

Scribes may perform a variety of functions, including doing pure transcription of the encounter, using templates or macros within notes, placing orders, finding information in the EHR for the doctor, or even responding to patient messages.

There's a great deal of focus being spent on a national standard for the credentialing of medical assistants and the certification for scribes. And when it comes to Meaningful Use and certified EHRs, there are lots of questions surrounding the topic.

CMS recently clarified its policy on the use of scribes and stated, "Due to recent law, we are revising our policy on scribes for the Medicare and Medicaid EHR Incentives Programs such that scribes may document

in an EHR as long as the physician delegates this action, signs and verifies the documentation and the action is in accordance with applicable State law." Additionally, California law does not yet require certification of scribes. But there is a lot of discussion about this requirement and from a medical liability standpoint, it makes good sense to utilize certified scribes within your practice.

Although there is very little regulation or standardization for scribe training, and researchers haven't conducted any assessment of scribes' ability to safely interface with the EHR, these risk strategies could reduce liability associated with the use of scribes:

- At a minimum, all scribe-generated orders should be signed by a provider prior to implementation.
- The practice should document the competency of the scribe for the functions the practice deems appropriate, especially with safe and effective use of EHRs.
- Routine quality checks should be implemented to identify areas for improvement in documentation.

### Conclusion

The combination of rapid growth in scribe use, lack of licensure, variability in scribe experience, and variability in both EHR exposure and EHR workflows raises a concern for all practices that utilize or wish to use scribes. Utilizing credentialed medical assistants and scribes benefits your practice by providing a reliable quality assurance mechanism, more efficient use of resources, and more EHR entries counted toward CMS incentive programs. ↩

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