IN YOUR FACE(BOOK)! SOCIAL NETWORKING & CLINIC LIABILITY

Well, we expected it to happen, we just didn’t know when. It had to happen — our first encounter with the social networking liability issues in the MACM community of clinics.

It starts out innocently, a staff member letting off steam at the end of the day, venting about anonymous patients or coworkers in an unnamed clinic entity in some Mississippi town. Pretty soon the Internet is brimming with enough information to pinpoint the town, the clinic, and the patient or co-worker. In military security training, this is called talk around, trying to convey a message through code words or vague references to the subject. It doesn’t work. However much we think we hide identities and facts, those closest to the subject can put everything together to make the story. Yes, we had that scenario.

Or, being the caring people we are here in the South, we want to let friends and relatives know what their kinfolk may be doing during their treatments for whatever ails them. After all, the family has set up a CaringBridge page for dissemination of information and for well-wishers to post notes of encouragement. Surely a comment from the clinic personnel encouraging their patient in his treatment would be welcomed. Yes? Well, maybe not. A posting from a family member or a friend may be welcomed, but only in their personal capacity, not in their capacity as a member of the patient’s health care team.

Confidentiality pitfalls with the technology of the Internet is no new issue, but the proliferation of the social networking sites has added a new twist to the problem. People sometime forget the line that must be drawn between their personal lives and their professional lives. The absolute stickler for protecting patient’s privacy by day may morph into the social butterfly of the Internet by night — without realizing what he or she has done. A September 2009, issue of the Journal of the American Medical Association (JAMA)¹ published an article in which they reported that, of the medical school deans who responded to a survey, 60 percent of them reported incidents involving unprofessional posting on social networking sites, with 13 percent reporting violations of patient confidentiality. Some of these postings resulted in expulsion of the student from the medical school.

What are some of the things a clinic can do to help prevent these transgressions and demonstrate that, in accordance with HIPAA regulations, it is taking the required steps to assure patient privacy?

- Establish written policies regarding the security of patient information, to include policies on photos (don’t forget those cellphone cameras!) and social networking sites. And include all clinic personnel—physicians, too.
- Include in your policies prohibitions against posting of clinic business or day-to-day clinic issues. Outline procedures for obtaining permission in cases of clinic marketing efforts or media involvement.
- Establish a strong orientation program for new hires, to include the security and privacy policies.
- Reinforce the policies through periodic training of all personnel.
- Post security reminders in clinic personnel areas.
- Inform all clinic personnel of the consequences of violating the policies, including the possibility of termination. Have them sign a confidentiality statement upon hire and annually thereafter.

Taking the above steps will help in preventing incidents arising out of social networking sites.

I would like to argue that assessing risks is one of the most fundamental tasks determining our survival as humans.

When we walk across a busy street; when we drive a car; when we decide to see a doctor, we all assess the risks before we act. At least most of us who survive uninjured do. Now the risk associated with physical activity depends on our ability to perform “vector analysis” and relate that to our physical abilities and goals—all tasks learned from an early age. Choosing a doctor and following his or her advice is a more difficult and different assessment.

We at MACM have found most people want to know the risks involved with a particular course of action. At least judges and juries seem to like to see documentation that it has been presented to them. I find it odd that so many of our insured physicians resist documenting that they tried to present the risks to a fellow human being. Granted, some patients do not want to hear the risks of a particular medicine or surgical procedure. I can only assume that they are deferring that assessment to their family, or the medical school or board of medical licensure or to the politicians. Our duty (so far) remains to our patients.

Risk Management Update Offered for Office Staff

A giant wave of older patients is headed your way! The Baby Boomers will be turning 65. And, what does this mean for your clinic? It means more patients with more chronic diseases requiring more time and more resources. Along with these challenges, there are increasing liability issues when dealing with an aging patient population. Medical Assurance Company of Mississippi claims experience over the last 10 years has shown that the majority of lawsuits are initiated by claimants between the ages of 40-59 years of age (35 percent), the second highest age group for initiation of lawsuits is over the age of 60 (27 percent).

So what can you do to keep from being swept away? The 2010 MACM Office Staff Program will focus on the issues of the aging patient population and steps you can take to keep your head above water. This program is for physicians, office managers, nurses, medical assistants, and any staff you feel would benefit from this information.

Orientation Program for Newly Insured Physicians

Newly insured physicians are required to attend an Orientation Program after their policy’s effective date with MACM. This program offers a history of the Company, as well as guidance on working with various department and staff. New physicians whose policy effect date begins January 1, 2009 or later, have one year from the month of policy inception to complete this requirement, e.g., if policy effective date is March 5, 2009, the new physician must complete the requirement by March 31, 2010.

Failure to attend one of the programs scheduled within your one year time frame will result in a 5 percent premium surcharge or $1000, whichever is greater. Continued failure to attend through the next policy period will result in a 10 percent surcharge or $1000, whichever is greater. If the requirement is not met within the third policy period, the physician will be considered for non-renewal.

New Physician Orientation meetings for the remainder of this year include meetings in Biloxi, Jackson and Tupelo. See the MACM website for more details and to register for either of these programs!
For MACM insured Southern Bone and Joint Specialists, P.A. in Hattiesburg, it wasn’t a matter of if, but when the clinic would convert to electronic medical records.

The clinic’s physicians and staff knew that EMR was coming and changing their busy orthopedic practice to a paperless system was something that they would have to do eventually. So, instead of waiting, SBJ took a proactive approach and jumped in knowing the long-term benefits were well worth the time and effort.

“We like to say that we try to be on the cutting edge, but not the bleeding edge when it comes to new technology and practice application decisions,” David Burckel, SBJ chief executive officer, said. “EMR is where medicine is going and we wanted to help develop with the industry.”

For such a significant commitment – financial, personnel, and time – it had to come from the top. During a meeting, the SBJ Board of Directors began the process and decided to start looking for a system to implement in the clinic. In 2005, Dr. Keith Melancon, Dr. James Sikes, Burckel, and Rodger Gamber, Chief Financial Officer, attended a Health Information Management Systems Society meeting in Orlando, Fla. They visited with 30 vendors, among the hundreds that were there. From that meeting and with much more research and information, a system was recommended for use at SBJ.

For other clinics beginning the transition to EMR, Burckel recommends lots and lots of research. “Consult with other clinics and involve your physicians as much as possible to get them to buy into the process.”

A group from SBJ visited Rebound Orthopaedics, an orthopedic clinic in Portland, Ore., to see how their EMR system, which was the same as SBJ’s proposed system, and PACS (picture archiving computer system) worked together. SBJ already used PACS, and EMR had to fit with that system.

Since PACS is integrated into the EMR system at SBJ, physicians can read films through the computer and use it to explain a diagnosis and treatment plan to a patient. In addition to an improvement in patient communication, there is a reduction in expense because there are no hard x-ray films and it is easier to view historical films because they have been integrated with the medical records.

The first implementation of SBJ’s EMR began five years ago, with as much work being done before the actual implementation began. Dr. Melancon was the first physician to use the EMR, and one physician at a time was added, taking a little over a year to get every physician trained and using the system. As new physicians are added to the group, they and their nurse are trained with a much easier and quicker learning curve.

Physicians also have the ability to use an off-site computer to pull medical records as needed. “It’s a wonderful tool to have while on-call,” Susi Folse, MD said. “I can pull up an MRI from my house. I can see all of the medical notes of my partners and I know what is going on and my decision making is reflective of that knowledge.”

From a physician standpoint, Dr. Folse has completely embraced EMR and believes it has made her job so much better. From simple communication with her nurse to patient interaction to the ability to view charts from home, she depends on EMR to run her clinic smoother and more efficiently.

“While in a patient’s room, I can look at something immediately. I can review a history and pull two films up on the screen to compare.” Dr. Folse said. “I can talk to the patient right there in the room rather than having to go back to the work area. I can fax in a prescription, communicate with my nurse, ask the billing department a question, all without leaving a patient alone in the room.”

Dr. Folse advises anyone considering EMR not to be afraid to do it. “It makes your life easier. There

Southern Bone and Joint Specialists
- Orthopaedic clinic in Hattiesburg, Mississippi
- 14 physicians in the practice
- 101 employees
- Three satellite offices in Mississippi
- Southern Surgery Center
is a downtime at first as you learn the system and what it can do. Patience is a necessity, but as the learning curve lessens, you’ll never return to a paper chart.”

The best way to get a physician on board with EMR, believes Dr. Folse, is to train the people around him or her. Educate the staff and everyone around and that will get the physician involved.

For the non-clinical part of the group, the implementation of EMR has been wonderful, according to Burckel. The staff has access to the charts without having to hunt down a paper chart or a physician for a question. More than one person can access the same chart at the same time. Everyone knows where patients are, how long they have been waiting, if they have paid their co-pay, etc. “It just makes the office run smoother and with a lot less walking traffic,” Burckel said.

From a patient perspective, it has made interaction with the clinic much easier. Requests for records are instant. Patients are not left stranded and waiting. For a patient who is seeing someone other than their primary physician, their chart is complete.

Another commitment that the clinic made to EMR is in personnel. SBJ employs one full time and one part-time IT person. In addition, Julie Shook is the EMR Administrator for the clinic. Her full time job responsibilities include a dedication to the software of the system.

“Everything that the physicians need to make their clinic run smoother, Julie can build or work with our vendor to get it built.”

What happens if a disaster strikes and the electronic medical records are destroyed? The clinic has a generator for the building and redundant servers on-site. In addition, there is a disaster recovery system off-site. Through this system, clinic staff can access the same information as if the servers at the clinic were working. And, even the off-site recovery system is regularly backed up. If needed, the clinic can convert to this off-site back up system, and, within 30 minutes, the EMR is fully operational again.