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PRF NEWS

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How Physicians Can Help Reduce the Risk of Firearm Injury

BY ALLISON GOODYEAR MD, FAAP

More than one in five adults in the U.S. owns a firearm. And despite the fact that California has the strongest gun violence prevention laws in the nation, every three hours a person in our state dies from a firearm-related injury. Because health care providers already regularly offer risk reduction counseling for behaviors such as proper seatbelt usage, swimming pool safety, and safer sex, I would maintain that we are in an equally unique position to aid in the prevention of injury due to firearms.

In order to intervene, physicians must first identify those patients at risk of harming themselves or others and then screen for access to firearms. Individual patient characteristics associated with firearm injury include a history of alcohol or drug misuse, a history of violence, or a history of dementia or cognitive impairment.

Sixty percent of people with dementia in the U.S. live in a home with a firearm and about half of those are stored loaded and unlocked. Other patients at elevated risk for firearm injury include young men of color (who are at high risk for homicide), older white men (who are at increased risk of suicide), and children (who are at risk for unintentional injury).

Approximately 20 percent of homes with children in the U.S. have guns that are stored loaded and unlocked. This fact alone puts six to eight percent of the country's children at risk for firearm injury. Screening for access to firearms and counseling regarding proper storage should be a starting point for these patients and families. Safe storage means that firearms are stored both locked and unloaded with ammunition stored separately.

No laws prevent physicians from asking about the presence of access to firearms in at-risk patients. The American Medical Association, American College of Physicians, American Academy of Pediatrics and other major medical associations recommend physicians ask about access to firearms and provide risk reduction counseling regarding safe storage. Physicians should be aware of their responsibilities in acute situations such as a patient with suicidal ideation, and should also be able to educate their patients and families regarding options such as a gun violence restraining order for less acute, but still potentially dangerous, situations.

GUN VIOLENCE RESTRAINING ORDERS

Currently, 17 states and the District of Columbia have gun violence restraining orders (GVROs), and California was one of the first. California's GVRO took effect on January 1, 2016 and allows law enforcement as well as family or household members to petition the court to temporarily prevent a person who is at risk of causing injury to self or others from purchasing or possessing firearms or ammunition. The person requesting the GVRO must prove that less restrictive alternatives have been tried and found to be ineffective, inadequate, or inappropriate in the patient's situation. If the GVRO is granted, the at-risk person must surrender the firearms and ammunition to law enforcement or sell them to (or store them with) a licensed gun dealer. If the at-risk person does not comply, a search warrant can be obtained for seizure of the firearms and ammunition. The groups of people who can request a GVRO will also expand to include employers, coworkers, and teachers in certain situations.

LIMITATIONS OF GUN VIOLENCE RESTRAINING ORDERS

Health care professionals are not able to petition for a GVRO themselves, but if coun-

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Inside PRF News

Record Retention: Out with the Old, In with the . . . Old?

MARLA N. STAYDUHAR, ESQ.

For over 15 years, the federal government has encouraged the expansion of electronic medical records (EMRs) in an effort to improve patient care as well as reduce costs and medical mistakes. Recent surveys by *Medical Economics* indicate that the majority of physicians have been utilizing EMRs for at least five years, and a quarter of those surveyed have been using EMRs for over ten years.

With the passage of this much time it becomes almost inevitable that there will be professional changes and experiences that may spur you to replace your current EMR system with a new or different one. The impetus for a change may include the need to accommodate a growing practice, moving to a new employer or health system, desiring different functionality or customization than your current EMR provides, or just plain economics.

Regardless of the motivation for the adjustment, migrating to a new EMR program requires that you address several concerns as you move to implement your new system. Perhaps the most important of these considerations is that you ensure that all patient health information and prior medical records are retained during the conversion to the new EMR. The retention of patient medical records is significant for several reasons:

- **Continuity of care**. Maintaining an accurate record of a patient's history, complaints, symptoms, physical examination findings, differential diagnoses, and treatment plan is essential to ensure your ability to provide consistent ongoing care. This is equally true for other consulting or treating physicians and health care providers who will require up-to-date information in regard to the patient's history, condition, and medications.
- **A complete record**. Other physicians who access your patient records are likely to presume that the EMR contains an inclusive and comprehensive patient chart, meaning that all records are accounted for and all patient data is available.
- **Patient access**. If your EMR allows patient access through a "portal" or other interface, a patient may want to access their own records prior to establishing new care or undergoing testing. The perception that information is missing will likely be confusing or concerning to the patient. This may exacerbate suspicions that medical care rendered was improper or spark accusations that a physician is attempting to hide aspects of prior care.
- **Administrative or judicial proceedings**. Should a patient's care become the subject of a civil malpractice lawsuit, the expectation of the attorneys for both the patient as well as the defense is that any request or subpoena issued for the entire medical chart includes all historical records through the timeframe requested. However, often a provider's office will only produce the records that are contained in the current EMR while there may be records sitting in an old EMR program that do not get identified or delivered. This may lead to several problems ranging from the inability to access patient health information that is relevant to the proceeding all the way through allegations of intentional destruction of evidence and fraud. The parties may waste countless hours litigating whether additional records exist for the patient and whether those records were intentionally withheld. This time could be better spent preparing for the medical defense rather than whether you kept your EMR up to date.
- **Preparing a legal defense**. Retention of all patient records is essential to refute claims of improper or negligent medical care. This is true whether such allegations are made informally by a patient, before the Medical Board, or in a civil lawsuit. The entries made in the medical records at the time of patient care may be more reliable than physician or patient memory. Likewise, the records may assist in refreshing your recollection surrounding the patient's history, complaints, and treatment. Therefore, access to all patient medical records is imperative for establishing that medical treatment rendered was appropriate and within the standard of care.

How long do medical records need to be retained?

There is no California law or HIPAA requirement that specifically sets forth record retention requirements for individual physicians' offices. Therefore, it is important to take into consideration the laws and guidelines in regard to patient record retention and apply those when changing your EMR system. Although a variety of different California health codes require different retention intervals of from two to 10 years, the California Medical Association recommends that the minimum amount of time for record retention should be 10 years after the last date the patient was seen. However, for maximum legal protection, records should be kept up to 25 years and indefinitely when possible.

When choosing a different EMR software and provider, you will need to consider how data migration and the transfer of patient health information and records into the new system will be accomplished. This will necessarily involve a determination of what information will transfer automatically versus whether some patient records will need to be transferred as scanned-in or read-only documents. This includes the capture of prior paper records as well as records that were also originally scanned into your old EMR. While requiring attention and even expense to be done accurately, the retention of prior patient health information and medical records remains of great significance in regard to providing superior medical care as well as protecting yourself and your practice from the pitfalls of patient grievances and litigation. ■

Marla Stayduhar, an attorney with Donnelly Nelson Depolo Murray & Efremsky in Walnut Creek, focuses her practice on defending health care providers against claims of medical negligence.

Telehealth Consent

BY SHANNON GATES, ESQ.

Before a telehealth encounter, a provider is required to inform the patient about the use of telehealth and obtain verbal or written consent. This consent must be documented in the patient's chart. PRF suggests adding a telehealth information and consent form to your new patient materials so the consent is in writing. This form should:

- Inform the patient about the use of telehealth
- Provide a complete and clear description of the telehealth services that will be provided
- Explain the specific telecommunication technologies being used and the manner in which you and your patients will use them
- Inform patients of the potential benefits of telehealth, including increased access to medical care
- Inform patients of the potential risks of telehealth, including clinical limitations, and transmission/technical difficulties that could lead to confidentiality issues
- Inform patients of the methods used to ensure confidential communication (for example, using secure and HIPAA-compliant telecommunication technologies)
- Make it clear to patients that:
  - The laws that protect the privacy and confidentiality of medical information also apply to telehealth, and their confidential information will not be disclosed without their consent
  - They have the right to withhold or withdraw consent for the use of telehealth at any time, without affecting their right to future care or treatment, and
  - They have the right to inspect all information obtained and recorded in the course of a telehealth interaction and may receive copies of that information for a reasonable fee
- Explain the fees that will be charged and whether they will be covered by insurance, and
- Obtain consent from the patient for the use of telehealth.

A sample consent form was e-mailed with this newsletter. ■

TELEHEALTH AND ARBITRATION

PRF requires providers to make a good faith effort to obtain a signed arbitration agreement before an initial patient encounter, with the exception of emergencies. This is obviously more difficult for a telehealth encounter. One option is to have the patient sign electronically. An arbitration agreement can be signed electronically if 1) the patient agrees, 2) the electronic agreement is an exact replica of the paper copy, 3) the patient's signature is written out electronically so the patient cannot dispute the signature, 4) the patient can print a color copy of the signed agreement, and 5) your office can print a color copy of the signed agreement.

Make sure to use a reputable vendor, such as DocuSign, that advises patients that their electronic signature is as official as their handwritten signature.

A second option is to mail a color copy of the agreement to the patient before the telehealth visit so the patient can mail back the signed agreement. ■

Firearm Injury *(cont. from page 1)*

seling regarding proper storage or removal of access to firearms is not successful, a physician can educate family or household members about the use of a GVRO. Furthermore, as mandatory reporters with a duty to warn, physicians can and should discuss their concerns with family or law enforcement. This discussion is not a HIPPA violation as HIPPA permits disclosure if that disclosure is necessary to prevent a serious and imminent threat to the health and safety of a person or the public. The disclosure must be to someone reasonably able to prevent or lessen the threat, such as a family member or law enforcement officer.

A GVRO cannot be used as the first line intervention to prevent firearm injury and may not be appropriate in every situation. For instance, if a patient has active suicidal or homicidal ideation, emergent referral for inpatient mental health treatment or to law enforcement would be more appropriate. Unlike other restraining orders, a GVRO does not restrict a person's access to certain individuals or locations. In cases of domestic violence, a different type of restraining order would be more appropriate.

A temporary emergency GVRO can be obtained without a court hearing and lasts up to 21 days, during which time a court hearing will be held. Currently, at the court hearing the GVRO can be extended up to one year. Starting September 1, 2020, the GVRO will be able to be extended for up to five years. The at-risk person may petition the court once a year to have it removed. Once the GVRO is removed the person will be able to purchase firearms and ammunition, and any that have been surrendered will be returned.

ADDITIONAL RESOURCES

For physicians wanting more information on firearm injury prevention, the What You Can Do initiative from the UC Davis Health Violence Prevention Research Program helps physicians learn how to identify patients at high risk of perpetrating or suffering from firearm injury, how to counsel regarding risk reduction with safe storage practices, and steps to take when there is imminent risk of harm, such as GVRO. Further information can be found in their free online CME course at **health.ucdavis.edu/what-you-can-do**.

Family members of at-risk patients who would like more information on the process to obtain a GVRO can find the information online at **speakforsafety.org** or the California Courts' website at **https://www.courts.ca.gov/33961.htm?rdeLocaleAttr=en**. ■

Allison Goodyear, MD, FAAP, a PRF Insured, is a pediatrician in practice with Pacific Pediatrics Medical Group in San Francisco.

New Statutory Requirements When Prescribing Opioids, Benzodiazepines, and Naloxone

BY SHANNON GATES, ESQ.

California law regarding the prescription of opioids, benzodiazepines, and naloxone was changed twice in 2019. The following points summarize these updated requirements.

1. When prescribing an opioid or benzodiazepine medication to a patient, a provider must offer the patient a prescription for naloxone hydrochloride or another drug approved by the FDA for the complete or partial reversal of opioid-induced respiratory depression when one or more of the following conditions are present:
   - The prescription dosage for the patient is 90 or more morphine milligram equivalents of an opioid medication per day.
   - An opioid medication is prescribed within a year from the date a prescription for benzodiazepine has been dispensed to the patient.
   - The patient presents with an increased risk for opioid overdose, including a patient with a history of opioid overdose, a patient with a history of opioid use disorder, or a patient at risk for returning to a high dose of opioid medication to which the patient is no longer tolerant.
2. A provider must provide education to the patient on opioid overdose prevention and the use of naloxone hydrochloride or another drug approved by the FDA for the complete or partial reversal of opioid-induced respiratory depression.
3. A provider must provide education on opioid overdose prevention and the use of naloxone hydrochloride or another drug approved by the FDA to one or more persons designated by the patient, or, for a patient who is a minor, to the minor's parent or guardian.
4. A provider is *not* required to provide this education if the patient receiving the prescription declines the education or has received the education within the past 24 months.
5. A provider is *not* required to provide either education or a naloxone prescription under any of the following circumstances:
   - When prescribing to an inmate or a youth under the jurisdiction of the Department of Corrections and Rehabilitation or the Division of Juvenile Justice within the Department of Corrections and Rehabilitation.
   - When ordering medications to be administered to a patient while the patient is in either an inpatient or outpatient setting.
   - When prescribing medications to a patient who is terminally ill.

   What is the definition of terminally ill? Terminally ill is defined as a patient who meets **all** of the following conditions:
   - In the reasonable medical judgment of the prescribing provider, the patient has been determined to be suffering from an illness that is incurable and irreversible.
   - In the reasonable medical judgment of the prescribing provider, the patient's illness will, if the illness takes its normal course, bring about the death of the patient within a period of one year.
   - The patient's treatment by the provider prescribing a controlled substance pursuant to this section primarily is for the control of pain, symptom management, or both, rather than for cure of the illness.

   What is the penalty for a failure to comply with these requirements? A provider who fails to offer a naloxone or equivalent prescription as outlined above, or fails to provide the education and use information required above, will be referred to the appropriate licensing board solely for the imposition of administrative sanctions deemed appropriate by that board. This section does not create a private right of action against the provider, and does not limit a provider's liability for the negligent failure to diagnose or treat a patient.

More information regarding the prescription of Naloxone Hydrochloride is available on the Medical Board of California's website at **https://www.mbc.ca.gov/Download/Documents/AB2760FAQs.pdf.** ■

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