Closing or Moving a Physician Practice

Background

The College of Physicians & Surgeons of Alberta (CPSA) provides Standards of Practice representing the minimum standards of professional behaviour and good practice expected of Alberta physicians. The Standards of Practice are enforceable under the *Health Professions Act* and are referenced in the management of complaints and in discipline hearings. Physicians who close, leave, or move a medical practice must follow the steps laid out in Standard 22, which pertains to practice management, including the maintenance of patient records.

Physicians and other health service providers are considered custodians of patient records. According to the *Health Information Act Guidelines and Practices Manual*, "A 'custodian' is an organization or individual in the health system who receives and uses health information and is responsible for ensuring that it is protected, used and disclosed appropriately" (Alberta Health and Wellness, 2011. Websites for cited resources are identified in the bibliography on page 7.)

The *Health Information Act* (*HIA*) defines a custodian as "a health services provider who is designated in the regulations as a custodian, or who is within a class of health services providers that is designated in the regulation" (*HIA*, section 1,ix). This includes health service providers funded privately or through the Alberta Health Care Insurance Plan (AHCIP). In this document management tip, the terms "custodian" and "physician" are used interchangeably.

Physicians are responsible for maintaining accurate and complete patient records and storing them securely. According to the *Health Information Act,* "An individual has a right of access to any record containing health information about the individual that is in the custody or under the control of a custodian" (section 7). Therefore, a physician who closes or moves a medical practice must make arrangements to provide patients with ongoing access to their records.

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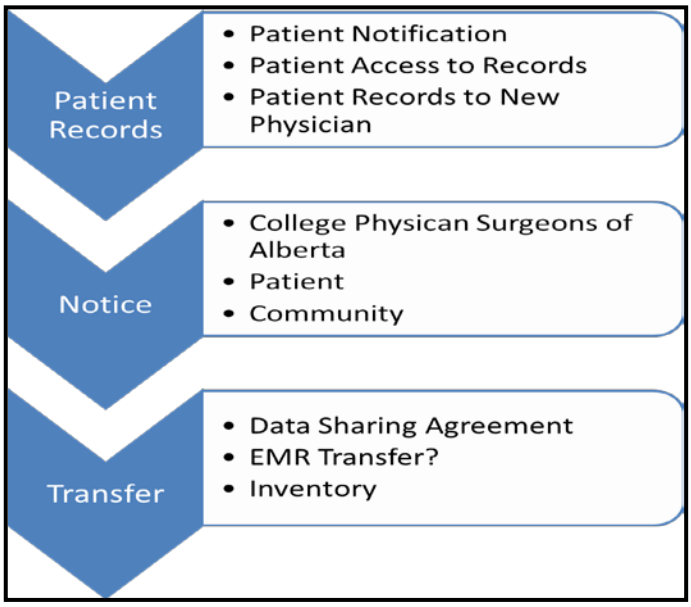

Custodians who operate a private primary care practice and subsequently close or move the practice are responsible for the secure storage and disposition of the individual patient records. This applies whether the custodians manage the storage of the records themselves or contract with other custodians or service providers. The *Health Information Act* (HIA) requires custodians to protect individually identifying health information in their custody or control by making reasonable security arrangements to protect against unauthorized access, collection, use, disclosure, or destruction.

The College of Physicians & Surgeons of Alberta (CPSA) provides Standards of Practice representing the minimum standards of professional behaviour and good practice expected of Alberta physicians. In the absence of a health service provider's regulatory college requirements, these standards are reasonable best practices that other health service providers can adopt for their records management practices.

Patient Access

The information in a medical record belongs to and must be provided to the patient when it is requested. In closing a medical practice, you can anticipate many requests to access records. Review, and revise if necessary, your written policies and procedures to ensure that you have an efficient process that accurately documents these requests.

Physicians who close a practice must ensure that patient records continue to be safe from reasonably anticipated risks and accessible to authorized individuals. In some cases, a physician may arrange to transfer patient records to another physician who will ensure their safekeeping and continue to provide patient access to them.

A physician also may contract with a service provider or an information manager (as defined by the *HIA*) to meet these obligations. The *Health Information Act* also allows a physician (custodian) to make agreements with information managers to provide information technology and information management services described in section 66. Whatever an information manager does on behalf of a physician must comply with both the agreement with the custodian and the *HIA*. The custodian is responsible for whatever an information manager does on his or her behalf.

The custodian has the right to charge a fee for access requests as defined by the *Health Information Act*, section 67, and *Health Information Regulation*, sections 9–12. The basic fee of $25 may be applied or waived by the custodian. Additional fees may be charged for producing a copy of a record. See the *Health Information Regulation* schedule. (For example, photocopies may cost $0.25 per page after the first 25 pages; producing a record from an electronic record may cost $10 per ¼ hour).

Notification

A physician must notify the College of Physicians & Surgeons before closing, leaving, or moving a medical practice in Alberta (CPSA, Standard 22, section 1). The notification must include the following:

- Information describing how the transfer of patient care will be managed
- Information about the location and disposition of patient records and how these records may be accessed
- A forwarding mailing address and contact information for the physician
- All unused triplicate prescription forms in the possession of the physician if he or she is closing a medical practice in Alberta

A physician must provide a minimum of 90 days notice of the medical practice closure or move to patients with whom there is an expectation of ongoing care. This does not apply to a physician if the reason for leaving a medical practice is illness or other urgent circumstances (CPSA Standard 22, sections 5, 6).

The leaving physician may wish to notify patients individually by post, through a community newspaper, in person when the patient attends the clinic, or by any combination of these or other methods. Personal letters to individuals and families demonstrate the physician's genuine concern for patients. See *Sample Letter to Patients*.

Posters in the clinic also advise patients and the general public about the upcoming changes. See *Poster for Clinic*.

A physician practising in the location where another physician had previously practised must provide information to any member of the public about the new location of the physician who has moved (CPSA Standard 22, section 7).

Ownership of Records

Clinical office records belong as property to the physician who produced them. Ownership of records produced in the course of group practice may require special consideration.

According to CPSA Standard 21, section 17, physicians in a group medical practice must determine custodianship arrangements of patient records within that medical practice so that:

(a) if a physician leaves the medical practice, custodianship of patient records will be clear to all parties and to the patients of the departing and remaining physicians, and

(b) the departing physician and his or her patients have reasonable access to the relevant patient records.

Ideally, physicians in a group practice will have documented their agreement or expectations relative to records management when the practice was first formed. Refer now to these agreements, or to *Data Sharing Agreement Outline for Physician Group Practices* (INFORMATION MANAGERS, 2009).

Data Sharing Agreement

If you didn't create a data sharing agreement when you opened your practice, we recommend you do this now. The following issues should be discussed, and decisions should be documented in writing.

- Will the remaining physicians of the clinic accept the ongoing management of the records?

  If the answer is yes, each individual patient's authorization to transfer the records is required. See *Authorization Form*.

- If a patient has not been seen recently and individual authorization has not yet been acquired, will the records be transferred to the remaining physician (or, if the practice has been sold, to the purchasing physician) as an information manager for secure custody, transfer as necessary, and destruction when that is appropriate?
- If the exiting physician has authorized the transfer of patient records to the remaining physicians, how will the exiting physician have reasonable access to the relevant patient records?

  Patients may authorize that their records in the custody of the current custodian (originating clinic) be disclosed to the exiting physician (*HIA*, section 34.1). A consent form authorized by the patient is required.

- If patient records are maintained in a shared database, as often happens in a group practice using electronic medical records (EMRs), how will the exiting physician and custodian of the records that he or she has authored have access to them? In what media (hard copy, electronic)? At what cost? Who will assume the cost, the departing physician, patients, or remaining physicians? These decisions must be included in an exit agreement and/or purchasing agreement. We recommend that you include your EMR vendor in this discussion to ensure that the selection criteria are the most efficient for your system. For example, one or more of the following options are possible:
  - During the daily use of the EMR, the most responsible (or primary or family) physician will be identified in each patient's record using the following data fields: scheduled physician / Alberta Health and Wellness billing / chart note author or default doctor.
  - Physicians leaving the clinic who may have authored patient records maintained by the clinic either on paper or electronically may request access to either paper or electronic copies of the patient records.
  - Paper records will be provided in hard copy or photocopy or may be scanned to pdf format.
  - Electronic patient records may be transferred by the clinic to a secured encrypted mobile media (e.g., DVD).
  - The group practice will authorize the EMR vendor to create a copy, extract, or transfer those patient records belonging to the custodian for the purpose of transferring them to the sole care and custody of the exiting physician. The cost will be determined by the EMR vendor and paid in advance by the exiting physician.

Secure Storage and Disposition

The *Health Information Act* requires custodians to protect individually identifying health information in their custody or control by making reasonable security arrangements to protect against unauthorized access, collection, use, disclosure, or destruction. The following are key points for your consideration.

- ***Transfer Requests***

'Disclosure' is defined by the *Health Information Act* as an event when a custodian provides health information to another custodian or to other entities. This also applies when you transfer the care of patients and their records to another physician. Review (and revise if necessary) your written policies and procedures to ensure you have an efficient process that accurately documents the request. A disclosure log or notation should be maintained, and copies of the authorized signed release forms should be included in each patient file. Disclosure notations must include the following information:

Who the disclosure was sent to

Date and purpose of the disclosure

Description of the information disclosed

If a patient asks a physician to transfer his or her patient records to a new doctor, the fee schedule under the *HIA* does not apply. The transfer of records to a new service provider is governed by fee guidelines established by the Alberta Medical Association.

If you transfer all records to the care of another physician, create an inventory of all records transferred. Ensure that you keep a permanent copy of this inventory listing. Provide the inventory list to the accepting physician. The accepting physician should provide an acknowledgment of receipt of all the patient records.

- ***Inventory***

Whether you plan to move, archive, or transfer the patient files to another custodian, you need to know what patient records you currently have. Prepare an inventory or list of all patient records that you have initiated during your practice. This often can be generated from existing data sources such as your billing or EMR system's central patient index. See *Inventory of Patient Records*. The inventory should include, at minimum, the following information:

- Patient's first and last name
- Date of birth
- First and last visit date
- Primary physician's name

- ***Records Retention***

Determine which, if any, records have met the minimum records retention policy and which could be securely destroyed. The College of Physicians & Surgeons Retention Schedule states that chart destruction may occur 10 years after the end of the year in which the last visit was recorded, and, for minors, at the end of the 10th year following the last date of service or until 2 years past the patient's age of majority – whichever is longer (CPSA Standard 21, section 9).

Ensure that you have documented which records have been destroyed, the method of destruction, and the date and signature of the person responsible for the destruction. See *Archive and Destruction Log* guidelines prepared by INFORMATION MANAGERS for sample instructions and forms.

Note: It may seem easier to keep records forever rather than destroy them after the retention periods and legislative requirements are met. However, remember that you may be required to produce or provide access to patient records for as long you continue to have custody of them.

- ***Information Manager***

If a physician closing his or her medical practice is unable to provide ongoing management of patient medical records, either personally or through a colleague, they should be put into commercial storage for custody, transfer as necessary, and destruction when that is appropriate. The above steps to create an inventory of patient records also apply here.

An Information Management Agreement (IMA) is a legislative requirement of the *Health Information Act*. Section 66(2) requires that the agreement be in writing; section 7.2 of the *Health Information Regulation* specifies the details of the agreement. Refer also to the Alberta Health and Wellness *Health Information Guidelines and Practices Manual,* Appendix 4, Components for Agreement with Information Manager, which provides an interpretation of the Information Management Agreement requirements.

Remember Your Exit Strategy

Whatever reason you have for deciding to close your business there are a number of steps to ensure that you meet your commitments to your patients, employees, colleagues, regulatory professional college, and legislation. The reasonable safeguards that you implement for the continued access, use, and disclosure of patient records is one key component of your exit strategy.

This publication provides general guidance for a medical office in Alberta. Consultation with your information systems, health records, and privacy office is recommended. For additional assistance, contact INFORMATION MANAGERS LTD.

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Sample Letter to Patients

Objective: Notify the patient that the physician giving the notice will be leaving the practice and to enable the patient to make alternative arrangements.

Instructions: Copy and paste appropriate wording to your Clinic letterhead. Keep a listing of patients which you have notified.

Physician's Notice of Absence or Closing of Practice

Dear _____,
(name of patient or guardian/parent of a minor patient)

This is to advise that I will be leaving my practice commencing _____ and
(date)

will not be available to provide care for my regular patients after that date.

I have made arrangements for care to be provided by:

Dr. _____, at _____
(new provider name) *(address)*

_____
(telephone)

If you are in agreement with transferring your care to _____, please indicate this by signing this letter and returning it to me. If you wish to have a different provider look after your care, please note this and make certain that the doctor has agreed to accept you as a patient. By indicating your choice, I will accept this as your authorization to make copies of the relevant records in your file and forward them to the provider you have indicated, and to advise that provider on any matter regarding your care that may be necessary.

If you have any questions, please do not hesitate to call my office at _____.
(telephone)

With many thanks for your understanding and assistance in making these arrangements.

_____
(name of provider)

_____
(signature of provider)

****

****

Authorization Form

For Patient:

By signing this document, I _____
(full name, date of birth)

hereby authorize to transfer any information from my files currently managed by

Dr. _____ to:
(current provider name)

Dr. _____, _____
(new provider name) *(address)*

and to discuss with Dr. _____ any matter concerning my condition for the purpose of taking over my care.

I acknowledge that I have been made aware of the reasons for the disclosure of the above information, and the risks and benefits associated with consenting to its release.

I understand that I make revoke my consent at any time, by providing a signed, written statement to that effect.

Date: _____ Valid Until: _____

Signature: _____ Print Name: _____

Poster for Clinic

(to be displayed in waiting room, exam room, etc)

Objective: Notification to patients when they present at the originating clinic. A physician practising in the location where another physician had previously practiced must provide information to any member of the public about the new location of the physician who has moved. (CPSA Standard 22, sections 7)

Instructions: Copy and paste appropriate wording to your Clinic letterhead.

This is to advise that I will be leaving my practice commencing _____
(date)

and will not be available to provide care for my regular patients after that date.

I have made arrangements for care to be provided by:

Dr. _____, at _____,
(new provider name) *(address)*

_____.
(telephone)

If you wish, you may contact me at my new location _____, or
(new clinic name / address)

by phone at _____.
(telephone)

You may also view the Clinic Website for additional information _____
(website address)

Access to Patient Records

You may request to have your patient records transferred to Dr. _____.
(new provider name)

Please request a form from the receptionist to authorize the transfer of the records.

If you wish to have your records transferred to another physician, please advise the receptionist. You will be given a form to bring to the physician of your choice. Make certain that the doctor has agreed to accept you as a patient. By indicating your choice, I will accept this as your authorization to make copies of the relevant records in your file and forward them to the provider you have indicated, and to advise that provider on any matter regarding your care that may be necessary.

If you have any questions, please do not hesitate to call my office at _____.
(telephone)

Inventory of Patient Records

Whether you plan to move, archive, or transfer the patient files to another custodian, you need to know what patient records you currently have. Prepare an inventory or listing of all patient records that you have initiated during your practice. This can often be generated from existing data sources like your billing or EMR system's central patient index. Remember to include patient records that may have been previously archived or moved to off-site storage.

If records do not have patient demographic sheet at the front of the chart, record the patient information in a separate document (sample below). To make retrieval of information easier, this could be entered into an excel spreadsheet or print patient labels and affix to create an inventory master list.

Last Name

First Name

Other Name

Date of Birth (spell month)

First visit date

Last visit date

Primary physician

Initials of Staff

Location of file