



Medical Economics
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Providing Patients Record Access

This article was originally published in Medical Economics and is written by Keith Loria.

Many physicians aren't aware that, with limited exceptions, HIPAA provides patients with the right to obtain copies of all of their medical records and allows them to see all original medical records, usually at a medical provider's office.

Shuhan He, MD, an emergency medicine physician at Massachusetts General Hospital, says one of the most common misconceptions is that patients somehow are limited in obtaining their own medical records because of HIPAA.

"Many smaller practices actually use it as a way to prevent patients from accessing their own records for fear of mishandling data in some capacity," he says. "What I always emphasize is that the legislation itself was called the Health Insurance Portability and Accountability Act. The rule actually encourages patients to access their own information and move it between practices, even if providers and healthcare entities are required to protect that information at a higher burden."

Providing the Records

Anwar A. Jebran, MD, a third-year internal medicine resident at Weiss Memorial Hospital in Chicago suggests practices use systems that are compatible with interoperability standards such as HL7 FHIR, an interface for exchanging electronic health records, which would eliminate much of the manual workload associated with accessing records.



"For practices without that, having a system to handle these requests with posted timelines works well," he says. "Corroborating information with the patient before adding it to their health records is also a good practice of verbally sharing the patient's health records and then giving them the option of either receiving a copy or managing their own documents."

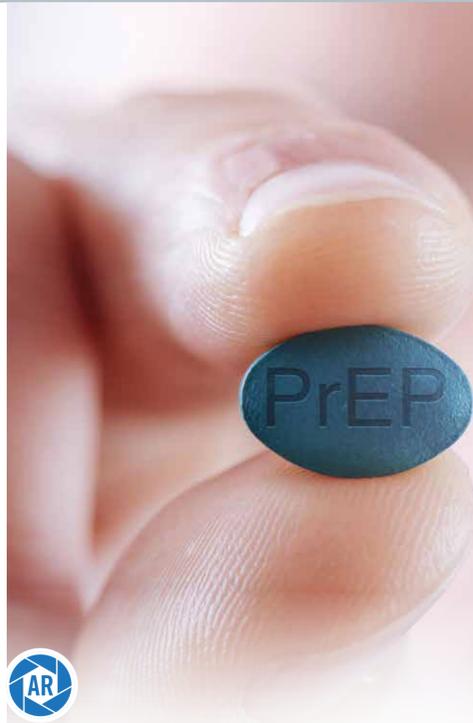
Money Matters

The HIPAA Privacy Rule permits a covered entity to charge a reasonable, cost-based fee that covers certain limited labor, supply, and postage costs that may apply in providing an individual with a copy of medical records in the form and format requested or agreed to by the individual.

However, the laws for copying medical records vary from state to state in terms of fees. For instance, in Florida, searches for medical records are \$1 per search per year, \$1 per printed page, and \$2 for microfilm. But it gets more complicated when you cross state lines.

The law is very clear. People have a right to their data, Jebran says. ■

To read the unabridged version, visit www.medicaleconomics.com.



CONFERENCE
CROI 2020
 HIGHLIGHTS

New research was presented at CROI 2020, the annual Conference on Retroviruses and Opportunistic Infections, from March 8-11 in Boston. The features below highlight some of the studies that emerged from the conference.

Sustained Viral Suppression With Rapid Start in Young Patients

Although the linkage-to-care intervention Rapid Start—designed to start patients newly diagnosed with HIV immediately on ART and to support equity in care—has been shown by prior data to improve linkages and viral suppression in adults, similar outcomes have not been verified among US youth. To do so, creators of the intervention developed a continuum of care for a young adult (aged 18-24) rapid start population and compared this continuum with an adult population. Patients were linked to a federally qualified health center within 72 hours of HIV diagnosis, with the first ART dose directly observed, patients provided with a 30-day dose pack, labs drawn, and

patients undergoing expedited insurance enrollment. Among youth participants, 97% achieved viral suppression with a median of 29 days from diagnosis, 84% remained virally suppressed at 12 months, and 97% remained engaged in care. Comparatively, viral suppression with a median of 28 days from diagnosis, viral suppression at 12 months, and remaining engaged in care were achieved by 98%, 93%, and 98% of adults, respectively. Differences between the two groups were not significant. "The intervention outcomes demonstrate that starting adults and youth on ART immediately after diagnosis, before labs are obtained, is safe, well-tolerated, and effective," write the study authors. ■

HIV Stigma & Retention in Care

Although evidence indicates that HIV-related stigma appears to be a barrier to engagement in care, large-scale, nationally representative studies prospectively evaluating the effect of stigma on retention in HIV care in the United States are lacking. To assess stigma, researchers added a validated, four-item assessment of internalized HIV stigma (1 = strongly disagree to 5 = strongly agree) to patient surveys administered every 4-6 months at primary care visits for patients seen at seven academic HIV clinics across the US. Among more than 5,800 patients who completed the stigma assessment, the median age was 49, 80% were male, 39% were black, 15% were Hispanic, and 32% identified as heterosexual. The study team

controlled for age, gender, race/ethnicity, sexual orientation, time since enrollment in the study cohort, and site of care. The mean stigma level was 1.9, with each unit increase in mean stigma associated with decreased odds of keeping the next primary care appointment (adjusted odds ratio [aOR], 0.93) and decreased odds of keeping all primary care appointments (median of 3) in the subsequent year (aOR, 0.91). The study authors write, "This is the first study to demonstrate prospectively the effect of stigma on retention in care, thereby providing support for the need to address HIV stigma in efforts to optimize retention in HIV care and virologic control." ■

Direct-Acting Antivirals & Healthcare Use

Empirical evidence supporting the cost savings associated with direct-acting antivirals (DAAs) in real-world populations, and thus wider access, is limited. To investigate the impact of successful treatment of hepatitis C (HCV) with DAA therapy on healthcare services utilization (HSCU), investigators used data from a study prospectively following nearly 2,000 HIV-HCV co-infected patients. The impact of sustained virologic response (SVR) on HCSU was evaluated among those who achieved SVR after initiating DAA. The model used in the study controlled for pre-treatment trends in HCSU, exposure time, time-updated covariates (CD4 cell count, HIV RNA,

active injection drug use, significant fibrosis), and fixed covariates (age, sex). Among 455 participants who completed DAA therapy, 424 achieved SVR. Out-patient visits decreased from 12.6 per person-year before DAA initiation to 9.4 post-SVR, while in-patient visits decreased from 2.8 per person-year to 1.4. Prior to DAA initiation, annual rates of emergency room (ER) and specialist visits increased, hospitalization and HIV visits were stable, and general practitioner and walk-in clinic visits decreased over time. Immediately after achieving SVR, hospitalization, ER, and specialist visits reduced and continued, with annual reductions of 13%, 6%, and 18%, respectively. ■

Prediction Model Evaluates PrEP Coverage

Evidence suggests that tools for identifying populations who may benefit from PrEP are required for monitoring progress in PrEP scale-up. Using a validated prediction model to estimate HIV risk, researchers evaluated PrEP coverage and disparities in use among nearly 3.3 million patients at high risk of HIV acquisition in a large healthcare system. The team used the prediction model to generate an HIV risk score for each participant based on historical EHR data. Pharmacy fill data were used to assess recent and ever PrEP use by HIV risk score strata. Chi-square tests were used to compare recent and ever PrEP use by demographic characteristics among those with very high risk scores. Among those with low and very high risk scores, recent PrEP use ranged from 0.02% to 40.4%, and ever PrEP use from 0.02% to 51.4%, respectively. "Of those identified by our model as being at very high risk of HIV acquisition, nearly 60% had not recently used PrEP and there were substantial disparities in use," write the study authors. "Efforts are needed to increase PrEP uptake in insured populations, particularly among females, younger age groups, those with lower socioeconomic status, and Black individuals." ■

Post-ACS Outcomes in HIV

Based on the hypothesis that HIV-infected individuals have higher rates of mortality following discharge from hospitalization for acute coronary syndrome (ACS), and receive sub-optimal medical management compared with uninfected individuals, researchers assessed data on more than 1.1 million patients admitted to the hospital with ACS between January 2014 and December 2016. While patients in the cohort with HIV were younger (57 vs 67 years) and had a higher burden of comorbidities like diabetes, renal disease, and substance use, ACS type did not differ significantly from those without HIV. However, patients with HIV had a higher adjusted 30-day, all-cause readmission rate (14.3% vs 9.4%), as well as a higher 1-year mortality rate (5.6% vs 5.1%). Yet, those with HIV filled prescriptions for core cardiac medications at lower rates during the 12 months after discharge, including for statins (66.8% vs 73.7%), beta blockers (67.9% vs 73.9%), nitrates (31.8% vs 35.9%) and antiplatelet agents (46.8% vs 51.8%). "Optimizing use of medical therapy and longitudinal care of this high risk group is greatly needed," write the study authors. ■

Antimicrobial Stewardship & Sepsis – A Great Debate

The following was originally posted by Kelly Cawcutt, MD, to the University of Nebraska Medical Center Division of Infectious Diseases blog.



Optimal management of sepsis has long been a holy grail in medicine. One area that remains fraught with debate is how to effectively balance the need for emergent antimicrobial administration with principles of antimicrobial stewardship. A recent Point-Counterpoint series on "Should Broad-Spectrum Antibiotics Be Routinely Administered to All Patients with Sepsis as Soon as Possible" published in *CHEST* highlights the debate. Disselkamp, et al. argue yes, early administration of broad-spectrum antibiotics increases the likelihood of adequate coverage AND is associated with decreased mortality. This does not negate the need for commitment to stewardship, but "If we do not use antibiotics for patients with life-threatening organ dysfunction, who are we saving them for?"

Conversely, Patel and Bergl argue that although delayed antibiotics do increase mortality in sepsis, the strong recommendation for empiric broad-antimicrobial therapy is inappropriate due to a paucity of high-quality evidence and risk of harm (such as adverse drug events, *Clostridioides difficile* infection) with "indiscriminate broad-spectrum antibiotics." They further argue that appropriate antibiotic therapy may not always be broad-spectrum, and the assumption that broad-spectrum is required is both flawed and potentially costly to patients and healthcare systems.

Further, perhaps this debate is not the most critical for our sepsis patients currently. Kashiouris, et al. demonstrated that delays in first antimicrobial execution (time from order to administration) are common and carry increased mortality, particularly for patients with many comorbidities. Regardless of what antibiotics are ordered, if not administered within the first hour, mortality continues to rise.

Do we have time to determine optimal antimicrobial therapy in sepsis when we frequently fail to administer it quickly enough?

How do we determine the greater good? Immediate mortality or potential downstream morbidity and mortality from adverse events?

Our patients rely on us for life-saving, timely antibiotics in sepsis and septic shock. Every minute matters—the time to diagnosis of sepsis, the time to ordering antibiotics, and the time to administration. Focusing on the drug choice, or time to ordering, is no longer enough. We must take a greater ownership over the entire process, including considering the speed of delivery, simultaneously, if we want to optimize care. ■

Telemedicine & Respiratory Infection Patient Satisfaction



Contributor
Charles B. Foster, MD
 Center for Pediatric Infectious Diseases
 Cleveland Clinic

Evidence suggests that patients are increasingly using telemedicine for non-urgent ailments, including pediatric respiratory tract infections (RTIs). "Antibiotic overuse is a problem in all care settings, but my colleagues and I wanted to better understand the challenges associated with diagnosing and treating RTIs in pediatric telemedicine encounters," explains Charles B. Foster, MD.

For a study published in *Pediatrics*, Dr. Foster and colleagues analyzed data from a nationwide direct-to-consumer (DTC) telemedicine platform focusing on antibiotic prescribing practices for pediatric RTIs. "We were interested in determining whether the parents' satisfaction with the telemedicine provider correlated with the visit length or whether an antibiotic was prescribed," says Dr. Foster.

The researchers found that pediatric patients were prescribed antibiotics in more than 50% of tele-visits. "Receipt of an antibiotic was the strongest single predictor of satisfaction, and the physician's prescribing rate correlated with their overall satisfaction ratings," Dr. Foster notes. Pediatricians, however, had a lower antibiotic prescribing rate than other physicians and overall higher satisfaction rates. Dr. Foster feels this may be because pediatricians spent more time with patients. When antibiotics were prescribed, there was no correlation between visit length and patient satisfaction. However, when no antibiotic was prescribed, satisfaction correlated with visit length, overall and for pediatricians alone.

The study showed high satisfaction rates among parents using DTC telemedicine for their child's RTI. Telemedicine is convenient and is becoming an important alternative to traditional care. However, Dr. Foster warns that "regardless of the practice venue, it's important for providers to strive to provide guideline-concordant care and to use antibiotics judiciously. In telemedicine, for example, this might mean that a child with suspected group A streptococcal pharyngitis needs referral to a laboratory or a clinic before antibiotics are started. You can't make that diagnosis without a throat culture."

Dr. Foster adds that hospitals and companies providing telemedicine services have an obligation to assess their own data to drive quality improvement initiatives. "Telemedicine providers who do this should be commended; the best healthcare organizations are passionate about continuous improvement," he says. "The platform is relatively new, so how to best do this is not clear. Perhaps, there are innovative technologies that can be used to improve the physical exam or partnerships that can facilitate diagnostic testing or in-person evaluations." ■

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