



[MEDLAW]

PART 1

Avoiding Liability in Telemedicine: Licensure & Coverage

Telemedicine has exploded in scope with the COVID-19 pandemic and will leave a lasting imprint on how medicine is practiced, so it is essential for physicians to understand its basic principles and the specific rules that govern it during the pandemic.

Normally, a patient's residence does not matter, because you see them in the state where you are licensed. However, when you see, for example, a doctor in Manhattan have a video visit with your patient at home just across the river in New Jersey, you are reaching into another state to practice and so your licensure status becomes of interest to that state. As a result of the COVID-19 crisis, states have extended licensure waivers. If you will be practicing telehealth with patients from states where you do not have a license, search fsmb.org for "states waiving licensure requirements" to make sure that is permissible.

Bear in mind that these modifications are related to the current pandemic. Do not assume that a waiver will continue past the end of the crisis, and make sure you meet all requirements that may re-establish if you want to continue to offer remote visits to your out-of-state patients, or you could face charges of practicing without a license.

The advent of the pandemic originally provoked a retreat by insurers, many of whom wanted to exclude COVID-related issues, but that was essentially a brief reaction, and virtual care coverage is now an expanding and competitive market. However, again, beware that while these changes are significantly the result of carriers seeing an expanding opportunity even after the pandemic ends, they are currently backed up by laws that offer considerable immunity from suits for those involved in COVID-19 care. That rates may rise later when such immunization is lifted should be assumed.

If you are getting coverage to do telemedicine, remember that it is not just about malpractice. You will need adequate coverage for technical issues and for privacy breaches. If you have free coverage of some \$50,000 for cyber issues on your current policy, make sure to increase it to at least \$1 million, because any breach can be costly and telemedicine is inherently more risky being entirely in the vulnerable electronic realm.

This article was written by Dr. Medlaw, a physician and medical malpractice attorney.



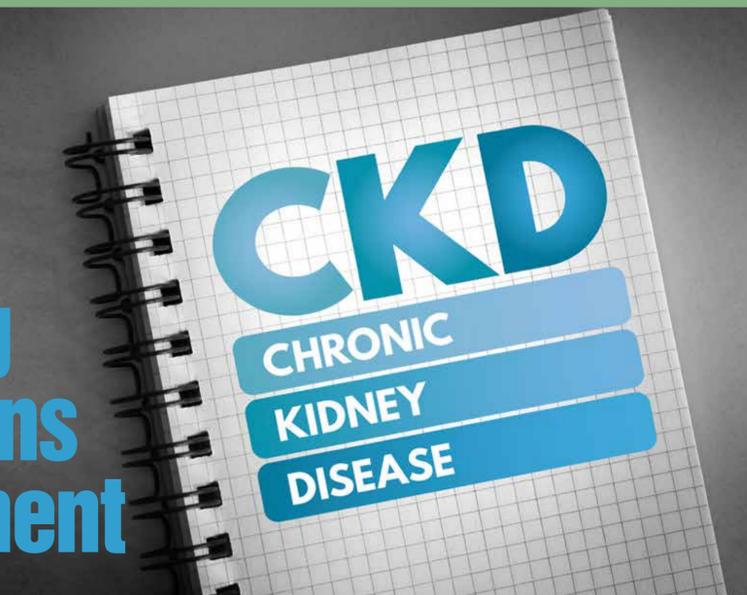
Caring for Older Patients With Advanced CKD: Assessing Perceptions on Treatment



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Older patients with chronic kidney disease (CKD) are often referred to educational sessions to learn about their different treatment options, including dialysis, and many develop end-stage renal disease (ESRD). "These patient education programs tend to focus more on modality type and vascular access than on how different treatment approaches may affect patients' lifestyles and goals of care," explains Nwamaka D. Eneanya, MD, MPH, FASN. "Furthermore, few patients with advanced CKD are made aware of conservative kidney management options or advance care planning." Conservative kidney management uses non-dialytic therapy to slow disease progression and treat a wide range of symptoms.

Unlike in other countries, the infrastructure to manage patients with CKD without dialysis in the United States is suboptimal. "Patients are often managed by nephrologists and primary care physicians (PCPs), but the educational messages they receive about treatment tends to focus on dialysis," Dr. Eneanya says. "Also, routine care for these patients often lacks multidisciplinary teams to provide social and emotional support



A study has identified important differences in experiences and expectations between clinicians, older patients with advanced chronic kidney disease, and their caregivers regarding treatment decisions and advance care planning for end-stage renal disease.

when engaging in treatment decision making. Unfortunately, many older patients with advanced CKD or ESRD do not fully understand dialysis. They view this treatment option as being their only alternative to death."

A Qualitative Analysis

Dr. Eneanya and colleagues performed a qualitative analysis published in *BMC Nephrology* to gain a better understanding of clinician and patient/caregiver perceptions of treatments for ESRD and advance care planning. Specifically, they explored the alignment of clinicians' views of their responsibilities and patient clinical experiences. Interviews were conducted with eight nephrologists, eight primary care physicians (PCPs), 10 patients (aged 65 and older), and five caregivers.

Dialysis discussions, dialysis decision making, and processes of advance care planning were key areas in which the expectations and/or experiences of nephrologists, PCPs, and patients did not align (Figure). Nephrologists were most comfortable with specifically managing renal disease, whereas PCPs felt their chief role was to advocate for patients and lead discussions on advance care planning. "In general, nephrologists and PCPs felt that nephrologists should take the lead when determining which patients are eligible for dialysis," Dr. Eneanya says. "However, PCPs

struggled with dialysis decisions made for patients who they felt would not fare well." Nephrologists and PCPs agreed that advance care planning was an important aspect of care and that PCPs should initiate these discussions with patients.

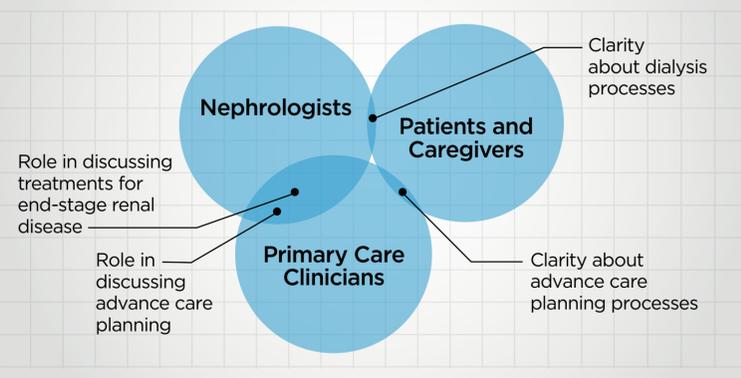
According to Dr. Eneanya, despite clinician alignment of their respective roles, patients and caregivers had many concerns about the impact of dialysis on their livelihood. "They also felt they were not fully aware of alternatives to treatment, such as conservative kidney management," she says. "Additionally, they did not feel they completely understood the concept of advance care planning. Both patients and caregivers wanted more information about treatment choices and advance care planning from their nephrologists. Ultimately, the perspectives of nephrologists and PCPs were aligned with each other but not with patients and their caregivers."

Communication Improvements Needed

Findings from the study highlight the need for efforts that aim to improve communication between nephrologists, PCPs, and patients. "This is an important unmet need for optimizing the care of patients with advanced CKD," says Dr. Eneanya. "These efforts will be critically important as institutions nationwide aim to implement strategies that improve patient experiences with kidney disease." Of note, in July 2019, HHS launched the *Advancing American Kidney Health* initiative to improve the lives of Americans living with kidney disease, expand treatment options for patients, and reduce healthcare costs.

More research is needed to determine if specific interventions like telemedicine or improved integration of electronic health records may improve communication between clinicians and their patients with advanced CKD. In addition, Dr. Eneanya says studies should seek to develop interventions that improve the infrastructure for effectively delivering nephrology care to older patients with advanced CKD. "The development and implementation of holistic collaborative models of care and efforts to enhance communication between all stakeholders is paramount," she says. ■

Figure Expectations & Experiences: How Clinicians & Patients/Caregivers Align



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Why We Need a One-to-Many Telehealth Model of Care

This article was originally published in *Medical Economics* and is written by Jon Bloom, MD.

One thing the COVID-19 pandemic has made clear is that telemedicine is a public health necessity. However, real-time, or synchronous, telemedicine isn't sustainable or scalable. We're already seeing synchronous telemedicine practiced on a small scale put a strain on our healthcare system during COVID-19.

For telemedicine to work at scale, it must also have a one-to-many component. In this model, data can be remotely gathered and consistently monitored over time and then used for timely and targeted communication between patients and providers. This allows care to scale from one-to-one to one-to-many.

Fortunately, a model already exists for how we can use asynchronous, one-to-many remote monitoring at scale for even the hardest-to-reach patients. The health system overseen by the VA is now successfully using asynchronous telehealth right now to ensure patients who cannot or should not visit a VA facility are still able to get the frequent care they need from a distance.

One such example is the effort to remotely monitor veterans at risk for diabetic amputations. Veterans place their feet on the Podometrics Smart-Mat for just 20 seconds a day in their home, and the temperature data captured is automatically sent to a care management team to monitor. When early signs of issues are detected, patients and providers are notified so clinical action can be taken quickly, helping to prevent more serious complications.

Such large-scale preventive care could not be achieved through synchronous, one-to-one telemedicine. There simply are not enough doctors available to check in with every patient for even 1 minute every day. However, remote asynchronous systems can gather data over time to help prioritize synchronous telemedicine, ensuring patients receive the care they need when it matters most.

A key takeaway of the current pandemic has been the importance of telehealth; however, for it to be sustainable, we need a combination of synchronous and asynchronous patient monitoring tools that allow for targeted communication. We should expect more healthcare providers to incorporate this kind of model to offer access at scale and save lives. ■

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

Post-Heart Transplant Osteoporosis & Chronic Kidney Disease



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“Recipients of heart transplantation (HT) require immunosuppression to prevent organ rejection,” explains Eveline Löfdahl, MD, PhD-candidate. “Unfortunately, osteoporosis—a well-documented adverse effect of immunosuppression—increases risk for bone fractures, which, in turn, increases morbidity and mortality rates. Furthermore, chronic kidney disease (CKD) is frequently found in the HT patient population and may also arise as a side-effect of the immuno-suppressive therapy.” To better understand the association between CKD, osteoporosis, and HT, Dr. Löfdahl and colleagues conducted a study that was published in *Transplantation Direct*.

“The study team investigated bone mineral density (BMD) progression and incidence of osteoporosis in conjunction with CKD in patients who underwent HT, following patients for up to 10 years (median, 6.1 years). Data from pre-operative transplantation assessments and post-operative annual checkups were used, including dual-energy X-ray absorptiometry (DXA) measurements from the lumbar spine and femoral neck to assess BMD.

Before HT, only 14% of the patients had normal kidney function, while 34% had CKD stage 2, 41% had stage 3, 5% had stage 4, and 0.6% had stage 5. Patients with CKD stage 1-2 or normal kidney function before HT experienced more than twice the lumbar spine BMD loss as patients with CKD stage 3-5 in the first year after HT. Patients with CKD stage 3-5 gained a mean lumbar BMD of 2.1% during the second postoperative year, while patients with CKD stage 1-2 or normal kidney function lost a mean lumbar BMD of 3.7%. In the femoral neck, all included patients exhibited a mean BMD loss at the first postoperative year, which was not reversed up to 10 years after HT. There was, however, no difference between the groups.

“Our study implies that pre-operative advanced stages of CKD are not associated with osteoporosis in HT patients, suggesting that patients with CKD should not be disqualified for HT based on the risk of impaired bone health,” notes Dr. Löfdahl. “However, evidence is limited due to the retrospective design and lack of data on fractures. Further studies on the relationship between CKD and postoperative bone strength, including fracture data, in larger patient cohorts and with prospective study designs are highly encouraged.” ■

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