



[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.

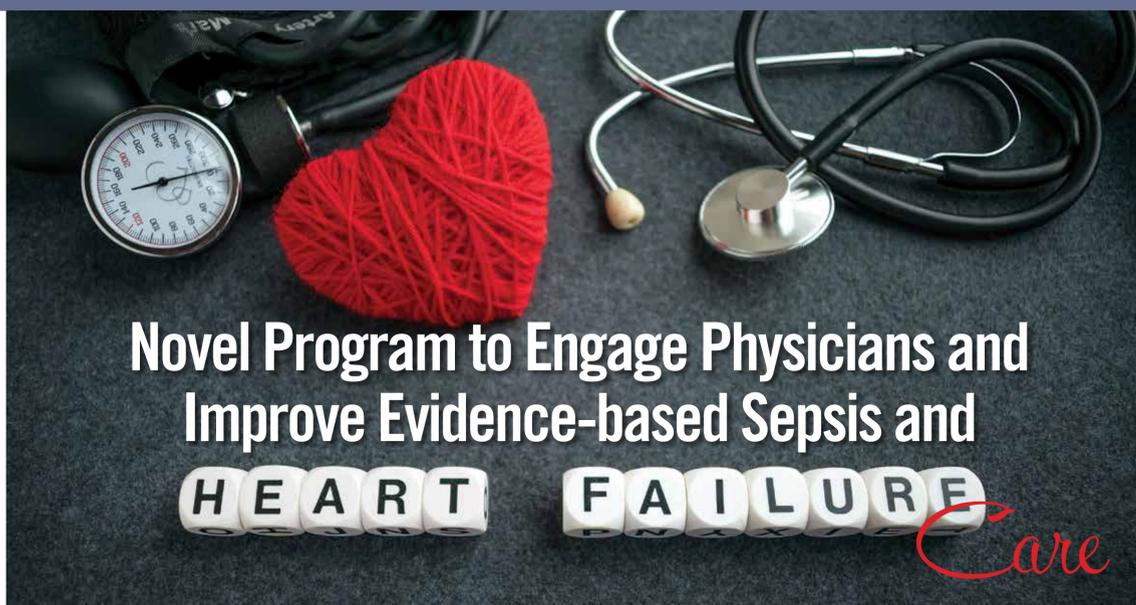
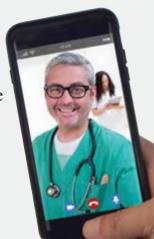
Normally, a patient's residence does not matter, because you see them in the state where you are licensed. However, when you as, for example, a doctor in Manhattan have a video visit with your patient at home just across the river in New Jersey, you are reaching into another state to practice and so 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.



Novel Program to Engage Physicians and Improve Evidence-based Sepsis and

HEART FAILURE Care



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Sepsis and heart failure (HF) are among the most mentioned hospital conditions when discussing unneeded treatment variation with health system CMOs, according to Trevor Burgon, PhD. Data suggest these two conditions are also the most frequent principal diagnoses among hospitalized Medicaid patients. Additionally, research indicates that sepsis is present in one-third to one-half of all hospital deaths, with HF listed as a contributing factor in more than 10%. Dr. Burgon and colleagues sought to determine if a patient simulation-based engagement program could significantly impact physicians' actual care decisions and reduce variation in sepsis and HF care at the bedside.

Virtual Patients

For a study published in the *Journal of Hospital Medicine*, Dr. Burgon and colleagues designed a library of online interactive clinical performance and value (CPV) sepsis and HF virtual patients designed to represent typical presentations and disease courses. Real-world quality and cost metrics from hospitalists at hospitals enrolled in the program were compared with a non-participating hospitals that were used as a control group to measure the impact of the program. Program goals were:

- 1 Measure how sepsis and HF patients are cared for using the CPV simulations.
- 2 Facilitate a forum for hospitalists to review their care decisions together.
- 3 Reduce unneeded variation to improve quality and reduce costs.

"Physicians need engaging, effective, and efficient ways to stay current on the latest guidelines," explains Dr. Burgon. "They want to deliver the best care, but are busy, trained at different places and at different times, and often don't have visibility into what their colleagues are doing."

The study team developed 12 CPV simulated cases (6 sepsis and 6 HF), with case-specific and guideline-supported scoring criteria. Possible scores ranged from 0% to 100%, with higher score reflecting greater alignment with best practice recommendations. Every 3 months over a course of six rounds, participants treated two virtual patients (20-30 minutes), received custom feedback on where they could improve, and then participated in group discussions to review the

data together. All participants treated the same patients, so the study team could understand where the group differed or aligned in treatment.

Big Improvements

To analyze the impact of the program, the team compared participant performance during the first two rounds with that of the last two rounds (Table 1). "With measurement and feedback, clinicians became better at making care decisions that were aligned with the latest evidence-based guidelines," adds Dr. Burgon. The scores showed an overall 7.8% relative increase, with improvements seen in all care domains. Improvement was significant in all domains except the workup, with the greatest improvement in diagnostic accuracy (+19.1%).

When they looked at the real-world data at the end of the first year, the team found that sepsis and HF patients cared for by participants enrolled in the program spent 892 fewer days than expected in the hospital. By the end of the 2-year program, participants in the program spent \$6.2 million less than expected to care for their sepsis and HF patients, driven by more efficient, more evidence-based care. An analysis by the team showed that these improvements, above and beyond the control group, came primarily from reduced variation between the clinicians.

"With the CPV simulations, we could pinpoint gaps in care and how these change with feedback," notes Dr. Burgon. "For example, we found high rates of unnecessary sputum cultures and urinary antigen testing for pneumonia patients who did

Table 1 CPV Score by Round & Domain

Scores are on a 0-100 scale, with higher scores reflecting greater alignment with best practice recommendations.

	Baseline	Final
Overall CPV Score	61.9	66.7
History	68.9	74.6
Physical Exam	89.4	91.8
Workup	74.6	74.7
Diagnosis	53.4	63.6
Treatment	52.1	56.7

Abbreviation: CPV, clinical performance and value.

Source: Adapted from: Yurso M, et al. *J Hosp Med*.

not have risk factors that would indicate such testing (Table 2). Through the serial feedback, the group became less likely to order these when they weren't indicated."

"We have found that combining short, validated patient simulations with individual and group feedback increases guideline-based care," says Dr. Burgon. "Over time, we saw that the clinicians were much more likely to make evidence-based care decisions in the simulations. At the end of the project, we then looked at the real-world, patient-level data and found that participating in this interactive measurement and feedback process led to significant reductions in length of stay and cost per case for HF and sepsis patients that were above and beyond improvements seen across the health system." ■

Table 2 Specific Items of Improvement

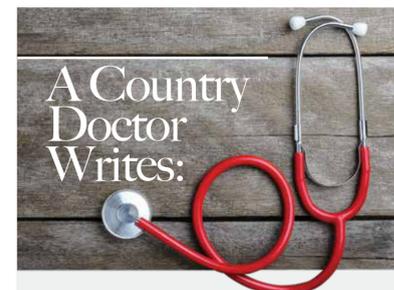
Scores are on a 0-100 scale, with higher scores reflecting greater alignment with best practice recommendations.

	Baseline CPV	Final CPV
Essential HF treatment elements	58.2%	72.1%
VTE prophylaxis for HF	16.6%	51.0%
3-Hour Sepsis Bundle		
All four components	46.0%	57.7%
Serum lactate	65.8%	81.5%
Blood culture	78.6%	83.9%
IV hydration	73.8%	73.0%
Antibiotics (any)	97.9%	100.0%
Low-Value Pneumonia Workup		
Unneeded urinary antigen	25.1%	10.5%
Unneeded sputum cultures	56.6%	30.2%
Adherence to preferred antibiotic regimens*	41.1%	47.5%
Discharge Planning		
HF	66.0%	69.9%
Pneumonia/Sepsis	42.2%	66.5%

*Comparison is between rounds one and three, due to changes in sepsis definitions and antibiotic regimens after round three.

Abbreviations: CPV, clinical performance and value; HF, heart failure; IV, intravenous.

Source: Adapted from: Yurso M, et al. *J Hosp Med*.



Meaningful Us

Meaningful Use was a vision for EMRs that in many ways turned out to be a joke. Consider my list of Meaningful Us for medical professionals instead.

When electronic medical records became mandatory, federal monies were showered over the companies that make them by way of inexperienced, ill-prepared practices rushing to pick their system before the looming deadline for the subsidies.

The feds tried to impose some minimum standards for what EMRs should be able to do and for what practices needed to use them.

The collection of requirements was called meaningful use, and by many of us, nicknamed "meaningless use." Well-meaning bureaucrats with little understanding of medical practice wildly overestimated what software vendors—many of them startups—could deliver to such a well-established sector as healthcare.

For example, the feds thought these startups could produce or incorporate high-quality patient information that we could generate via the EMR, when we have all built our own repositories over many years of practice from Harvard, the Mayo Clinic, and the like or purchased expensive subscriptions like UpToDate. As I have described before, I would print the hokey EMR handouts for the meaningful use credit and throw them in the trash and give my patients the real stuff from UpToDate, for example.

I'd like to introduce an alternative set of standards, borrowing the hackneyed phrase, with a twist. **Meaningful Us for Medical Professionals:**

Unbiased, Understanding, Unflappable, Unhurried

Like the software meaningful use items, these may be hard to attain, but especially in today's healthcare environment, they seem worthy of striving for.

UNBIASED Able to fairly represent alternative approaches to allow patients to make up their own mind about their care.

UNDERSTANDING Able to listen to patients' concerns and reflect back that you "get it" and will work to help address them.

UNFLAPPABLE Able to, in Osler's words, maintain equanimity in the face of the challenges of medical practice.

UNHURRIED Able to use time wisely, therapeutically, without frenzy, to make the most of the most valuable resource we all have.

Now, isn't that more inspiring?

Infection-Related Hospitalization & Mortality in Patients With Psoriasis



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Although previous studies suggest that psoriasis may be independently associated with an increased risk of serious infection—which leads to hospitalization—the research had various limitations, and thus, the relationship remains unclear, explains Zenas Yiu, PhD. In a study published in the *British Journal of Dermatology*,

Dr. Yiu and colleagues sought to determine if patients with psoriasis, when compared with those without the condition, have a higher risk of hospitalization due to any infection, respiratory infections, soft tissue and skin infections, or death due to infection.

Using data from the nationally representative UK Clinical Practice Research Datalink linked to Hospital Episode Statistics (HES) and Office for National Statistics (ONS) mortality records between January 2003 and December 2016, the researchers matched adults with psoriasis with up to six comparators on age, sex, and general practice. Hospitalization due to infection was ascertained from HES records and death from ONS mortality records. Stratified Cox proportional hazard models were estimated, with stepwise adjustment in different models for confounding factors, including BMI, smoking, alcohol intake, socioeconomic status, and comorbid conditions. Approximately 70,000 patients with psoriasis and nearly 340,000 comparators were followed for a median of about 5 years.

"People with psoriasis had a higher incidence rate of serious infection, at 20.5 per 1,000 person-years, than the comparators, at 16.1 per 1,000 person-years," says Dr. Yiu. "After adjustment, people with psoriasis had a 36% increased relative probability of developing a serious infection during follow-up compared with the general population (hazard ratio, 1.36). However, this only translated to three out of 100 more people with psoriasis developing a serious infection after 10 years of follow-up, compared with the general population."

Dr. Yiu notes that while patients with psoriasis were found to have a small but increased risk of serious infection when compared with those without the condition, "because the absolute increased probability of serious infection is small, people with psoriasis should not be unduly concerned. We recommend further research to investigate whether this slight increase in the risk of infection can be explained by biological mechanisms." ■



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