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PART 2

Avoiding Liability in Telemedicine: HIPAA & Informed Consent

That you are a responsible covered entity under HIPAA and a fiduciary for the privacy of your patients' PHI do not decrease with telemedicine. In fact, it is a setting in which you want to be very careful, particularly if working from home, where family will be present and habits may become lax. Your primary obligation is to make sure no unauthorized individual encounters PHI in any form.

However, the Office of Civil Rights (OCR) will waive penalties for HIPAA violations that would otherwise accrue due to this issue during the COVID-19 crisis. The intention is to open a telehealth option to practitioners who were not set up for such but who find themselves with patients in need of any telehealth diagnostic or treatment, even if not directly related to coronavirus.

The OCR extended permissible use to non-public-facing apps such as Skype, Google Hangouts video, and Zoom, that only allow intended parties to participate. A Business Associates Agreement is not required.

The standard during this waiver is one of good faith. If PHI is intercepted during transmission but the practitioner followed the OCR's guidance, there will be no penalty. Note, however, that states often have stricter regulations, and the federal waiver does not affect these.

Increased access also carries the important responsibility of informed consent. Many states specifically require that it be done and documented before engaging in a telehealth visit. In most such states, verbal consent is allowed, but consent must be obtained in writing in some. Regardless, the more certain the proof of consent, the better.

You should first inform the patient that this method is limited as compared with an in-person evaluation and is also potentially not secure. You should then get an affirmative consent to continue. If possible, build the consent form into the software so that the patient is required to assent before the virtual visit. If that is not possible, create a standardized e-mail with the consent and have the patient return it before you start. A verbal consent, if permissible, should be carefully documented.

You must apply all encryption and privacy modes available from your end. Increasing usable systems to ones that are inherently less secure is predicated on you doing what you can to minimize the risk of a breach, and it is this that the OCR will look to in determining a "good faith" use of the waiver. If a relative or friend or caregiver will be involved to help the patient with the televisit, make certain that you have a release that allows them access to PHI. Remember that the waiver on non-HIPAA compliant systems will only last during the emergency.

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

Allergist & Immunologist Wellness During COVID-19

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COVID-19 has prompted rapid global societal change. New word combinations were introduced and made commonplace in our vocabulary, such as social distancing, masking, and flattening the curve. As this pandemic spread, the burden felt among healthcare workers who were already experiencing burnout in our medical system increased exponentially. Data sets started to grow; however, the true number of cases and the case fatality rate (CFR) remained unclear. In addition, the concepts of social distancing and masking varied across the globe. Furthermore, the swift, constant modifications of guidelines and medications led to the spread of misinformation. As the need for understanding and science grew, clinicians had difficult decisions to make for themselves, their families, and their patients. This pressure has left little time for clinicians to focus on personal wellness, despite it being a critical piece of their success.

A Look Back

Glancing back historically, one can see similarities between tuberculosis (TB) and SARS-COV-2. During the 19th century, the mortality rate of TB was high and put a stress on the healthcare system. Social distancing helped to reduce the rate of spread. Misinformation was rampant, as original theories of "cures" were gradually laid to rest and true therapies emerged via research. Having this perspective does not make the current climate with COVID-19 any easier, but it does provide us hope that this too shall pass.

At the start of the pandemic, physicians throughout the world had to make not only difficult medical decisions for their patients, but also had to worry about keeping themselves safe. There was a need to ensure an adequate supply of personal protective equipment (PPE) in the face of national shortages. Providers faced dilemmas from access issues while trying to provide timely, effective, and safe care.

Navigating Uncertainty

During these times, social media has played a pivotal role in the dissemination of information about COVID-19. The key to this form of communication is to beware of misinformation and information overload. Finding reputable sources of material for learning, connecting with others for positive networking, and limiting online screen time can be a healthy way to utilize these resources.

In navigating uncertainty during this pandemic, it is important to have a plan and appreciate that the plan may change. At the start, many outpatient clinicians had to define essential services for their clinic and decide what they were comfortable doing. Many adopted telehealth as a means to continue to provide necessary and valuable care to their patients. Guidance had to be put into place to accommodate the new workflow and working with children and other loved ones in the home setting.

Balancing both extraordinary and ordinary stresses of practice continues to be challenging. Compounding stressors can increase burnout risk. In a survey of the American Academy of Allergy, Asthma, and Immunology before the pandemic, 35% of members reported burnout. While this is slightly lower than the overall rate of burnout among US physicians (estimated 45%-54%), it is a reminder that we each must create time and space to care for ourselves. Burnout is not uncommon in medicine, and now in a global pandemic, the risk is even greater.

Adapting to Change

Within the specialty of allergy and immunology, and across the continuum of medical practice, change has been rapid. Depending on the region of the country, allergy and immunology practices may have closed, may have stayed open for limited services such as biologics and/or immunotherapy, or may be trying to safely accomplish in-person visits. Further making it difficult for allergists to decide how to triage patients is that COVID-19 symptoms can overlap with common allergy and asthma symptoms, including dry cough, shortness of breath, tiredness, sore throat, congestion or runny nose, decrease in smell or taste, and headache. The need to adapt swiftly to emerging research, policies for telemedicine and insurance, and to navigate local COVID-19 testing access has placed further stress upon clinicians trying to keep patients and themselves safe.

It is important to appreciate how change impacts wellness, including varying stages of grief and acceptance, which are essential for personal advancement and wellbeing. If you feel yourself slipping off the edge, get help. Confidential help is available for those struggling with mental health, alcohol misuse, or substance abuse through the Federation of State Physician Health Programs and the National Suicide Prevention Hotline (800-273-8255). During this time, it is important to connect with others socially and meaningfully. If "alone time" or a break is needed, take it. Just as compassion is practiced with colleagues and patients, it should be practiced for physicians and other clinicians themselves.

To successfully adapt to these transitions, physicians should know that many tools exist to assist in their progress. Easily accessible apps can be worked into a daily routine quickly. Adopting a "strength-focused and meaning-oriented approach to resilience and transformation" may help clinicians grow personally to deal with the frustrations they feel. Practicing mindfulness and gratitude is key. Engaging in a gratitude journal, spiritual or religious practice, or meditation are helpful channels of clinician wellness. Remember to take care of yourself physically, mentally, and spiritually.

COVID-19 has transformed our lives. Through these trying times, we must incorporate wellness into daily routines to not only aid in preventing burnout and depression, but also to encourage ourselves and each other to grow and be hopeful to see the light at the other side.

33 CHARTS

Refusing Telemedicine – Can Patients Opt-out of Remote Care?

With the sweeping rise of COVID-19, telemedicine has taken healthcare by storm. During the local surges, this served as a mandated way of maintaining safe distancing. But as things come back to a new normal and as we decide where telemedicine fits in to a clinic structure, it might be worth asking: should patients have the option for in-person care? Is refusing telemedicine in favor of being physically seen a choice patients should be able to make? As we begin to settle in to a fixed role for telemedicine in the post-COVID world, centers are beginning to shape processes around telehealth.

Three assumptions that we make about patients and virtual encounters give shape to our policies:

ASSUMPTION OF APPROVAL

We assume that telemedicine is what patients prefer. The belief that patients prefer to be cared for in the context of their home isn't always the case. There may be sensitive issues or a hidden agenda that doesn't show well across a screen.

ASSUMPTION OF EQUIVALENCE

We assume that telemedicine is as good as in-person care. There is a bias to try to assess virtually some conditions that may best be assessed in real life. But, sometimes, medicine needs to be inconvenient.

ASSUMPTION OF CAPACITY

We assume the patient is able to participate in a virtual visit. Some families lack Internet access and equipment to complete a telemedicine visit.

Tech insecurity is a bigger issue than thought initially when we started doing telemedicine.

There are many reasons why a patient may prefer an in-person visit. Our assumptions about the magic of telemedicine are not always right. While we should work to accommodate the preferences of the patient, patients need to understand that there are conditions and circumstances where an in-person visit is not necessary. And patients should be offered the right of refusing telemedicine.

Will our telemedicine policies pull us back to an imbalanced doctor-patient relationship? After the COVID dust falls, we need to create more structure that respects the interests and will of the patient. Telemedicine is a moving target. What works or doesn't work today may have a very different solution or experience a year from now. Flexibility and rapid reiteration of our processes will be critical to successful adjustment and growth.

Visit 33charts.com to read the full article.

In Case You Missed It

Vitamin D Supplement No Benefit in Pediatric Persistent Asthma

Vitamin D3 supplementation does not prolong the time to severe asthma exacerbation among children with persistent asthma and low vitamin D levels, according to a study published in the *JAMA*. Study investigators randomly assigned high-risk children with asthma (aged 6 to 16) taking low-dose inhaled corticosteroids and with serum 25-hydroxyvitamin D levels less than 30 ng/mL to either 4,000 IU/day vitamin D3 or placebo (96 children in each group) and maintenance with fluticasone propionate. The time to a severe asthma exacerbation was examined as the primary outcome. The researchers found that 37.5% and 34.4% of participants in the vitamin D3 and placebo groups, respectively, had one or more severe exacerbations. Vitamin D3 supplementation did not significantly improve the time to a severe exacerbation compared with placebo, with a mean time to exacerbation of 240 and 253 days in the vitamin D3 and placebo groups, respectively. Compared with placebo, vitamin D3 supplementation did not significantly improve the time to a viral-induced severe exacerbation, the proportion of participants whose dose of inhaled corticosteroid was reduced, or the cumulative fluticasone dose. "Vitamin D3 supplementation did not lead to a significant improvement in the time to a severe asthma exacerbation," the authors write. "Moreover, vitamin D3 supplementation had no significant beneficial effects on any of the trial's secondary end points."

Many Pediatric Practitioners Do Not Advise Waiting Between New Foods

Most pediatric practitioners do not counsel families to wait three days or longer between introducing new foods for infants, according to a study published in *JAMA Network Open*. Researchers characterized pediatric practitioner recommendations regarding complementary food introduction and waiting periods between introducing new foods. Data were included from 563 survey responses from practitioners, including pediatricians, resident physicians, and nurse practitioners (80.6%, 15.1%, 3.6%, respectively). The researchers found that 38.6% of the practitioners recommended waiting 3 days or longer between food introduction; for infants at risk for food allergy development, 66.3% recommended waiting that amount of time. Overall, 46.9% of practitioners recommended infant cereal as the first food, and 40.1% did not recommend a specific order of foods. For exclusively breastfed (EBF) infants and non-EBF infants, 47.6% and 34.3% of practitioners, respectively, recommended food introduction at 6 months; 31.8% and 42.5% recommended food introduction at 4 months for EBF and non-EBF infants, respectively. More than half of practitioners (55.1%) reported a need for additional training on complementary food introduction. "Because the approach to food allergy prevention has changed, a reevaluation of published feeding guidelines may be necessary," the authors write.