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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.*

# Behavioral Therapy Preferences in People With Migraine

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***A study assessing behavioral therapy preferences in people with migraine found that there does not appear to be a one-size-fits-all approach. Clinicians should advocate for better behavioral therapy coverage to improve uptake of these helpful nonpharmacologic therapies.***

Published studies have shown that biofeedback, cognitive behavioral therapy, and relaxation are safe and well-tolerated nonpharmacologic strategies for migraine prevention and may provide long-term benefits. "We know that these treatments can be effective as monotherapy and can also be used together with migraine medications," says Mia T. Minen, MD, MPH. "However, studies indicate that many of these treatments are largely underutilized."

Finding time to attend appointments and costs associated with nonpharmacologic therapies have been identified as barriers to using behavior therapy in migraine in previous research. A recent study by Dr. Minen and colleagues found that only about half of patients with migraine who were referred for behavioral therapy inquired about making an appointment. "In this analysis, we identified time and money as the main barriers to using behavioral therapy," Dr. Minen says.

In a different randomized controlled study, Dr. Minen and colleagues assessed whether telephone-based motivational interviewing (MI) sessions increased the initiation, scheduling, and/or attending of behavioral therapy appointments for migraine prevention. "The MI calls increased rates of initiation but did not increase rates of scheduling or attending appointments," says Dr. Minen. "This was likely the result of other systematic barriers."

## New Research

For a new analysis published in *Headache,* Dr. Minen and colleagues assessed preferences for delivery of behavioral therapy with in-person treatment or via smartphone or telephone and reviewed the impact of insurance and other cost factors. The study surveyed whether people with migraine had preferences regarding the type of delivery of behavioral therapy and whether they would be willing to pay for in-person behavioral therapy. The authors also assessed if there were any predictors of likelihood to pursue behavioral therapy.

"Given the low usage of these effective interventions, our survey was conducted to better understand the behavioral therapy preferences in people with migraine," says Dr. Minen. In total, the study included 401 participants who screened positive for migraine using the American Migraine Prevalence and Prevention screen. The median age of the study group was 34 years, and more than two-thirds of the cohort was women. Participants reported having a median of 5 headache days per month.

## Key Findings

According to the study, only 12.5% of patients with migraine used evidence-based behavioral therapy, but when asked if interested in this treatment, many participants reported being "somewhat likely" to try it. Study patients reported being "somewhat likely" to pursue in-person or smartphone behavioral therapy and behavioral therapy covered by insurance. Respondents were neutral about pursuing telephone-based behavioral therapy. Of note, participants were "not very likely" to pay out of pocket for the behavioral therapy (Figure).

"Our data showed that there is no one-size-fits-all situation for patient preferences in migraine," Dr. Minen says. "Some people may prefer in-person sessions while others may prefer smartphone delivered therapy. People are willing to engage in behavioral therapy if it is covered by insurance. However, they are less likely to engage in this treatment if it is not covered by insurance." Pain intensity was predictive of likelihood of pursuing behavioral therapy for migraine when covered by insurance. Other factors were not deemed predictors, including education, employment, and headache days.

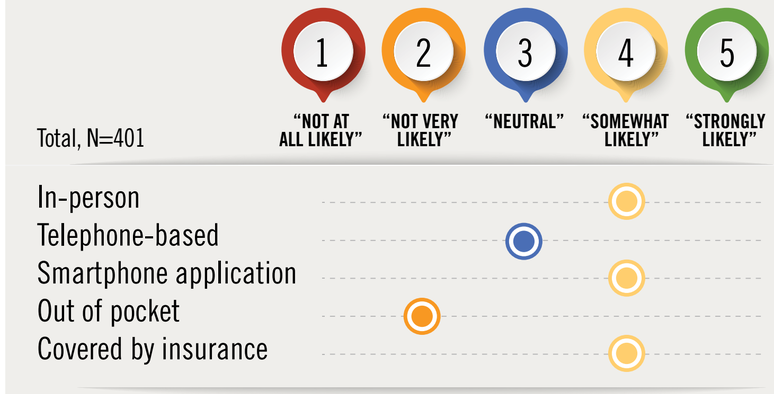
## Important Implications

According to Dr. Minen, efforts are needed to advocate for behavioral therapy coverage. "Clinicians should take time to find behavioral therapy resources in their area that may be covered," she says. "It is helpful to explain to patients that their treatment does not need to be billed under mental health codes. Instead, it can be billed under behavioral health codes, which may help patients who do not have mental health coverage."

In the future, Dr. Minen says more comparison studies are needed to assess different treatment delivery modalities. "We should determine the minimum dose required to achieve benefit," she says. "In addition, we need point-of-value analyses and more cost effectiveness research for behavioral therapy for migraine. Most importantly, it would be beneficial to investigate ways to create scalable, accessible forms of evidence-based behavioral therapy for patients."

**Figure** Likelihood to Pursue Behavioral Therapy

The figure below depicts the reported likelihood of patients with migraine pursuing behavioral therapy. Responses were recorded on a 1-5 Likert scale (1 = "not at all likely," 2 = "not very likely," 3 = "neutral," 4 = "somewhat likely," and 5 = "strongly likely").




**Source:** Adapted from: Minen MT, et al. *Headache.* 2020;60(6):1093-1102

MEDPAGE TODAY's
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## To Wear a Mask Is to Be Brave. To Trust Your Doctors Is to Be Brave

*By Abubakr Chaudhry, MD*

The pandemic is a lie. I will not wear someone else's fear. This is all fake news. It is remarkable to see these statements littered across the news and social media. Individuals with a fairly decent level of understanding and intelligence pandering to these ideas just go to show how strong anti-science culture has become.

On January 19, the first American would test positive for the novel coronavirus. By early February, the hysteria would start to set in and social media would start increasing speculative reporting. By late February, the stress and arguments about who should take responsibility began to boil over. Then there was the increase in fear among healthcare exposure rates, conflicting case fatality reports, and frustrations with the CDC on the flip-flopping in guidelines.

We became tired of the complaining, fear, and misinformation, so we decided to pen a guideline for our hospital. Georgia went on lockdown April 3. Throughout March and April, the world seemed to trust us as the scientific community to lead them through this crisis.

By April, we saw our algorithms were working, and we had some of the best outcomes in the state. People were adhering to the guidelines by staying home. Businesses had shut down, the spread was contained, and we could see the light at the end of the proverbial tunnel. Then, on April 24—with 892 deaths and 22,147 infected in GA—the lockdown restrictions were eased in our state. We were one of the last to close but the first to reopen. We knew the world needed to open; we just didn't know our world would open like this. I remember wondering why we couldn't mandate masks, contact tracing, and social distancing when we reopened. The virus became political.

When I started writing this, I was upset at a social media comment I read from a friend that read, "This pandemic is a joke, I will not wear a mask because I will not wear their fear." Now, I see that he was afraid and uninformed. People, in general, are still afraid, if not of the virus, then of loneliness, poverty, or even subjugation. When people exhibit these fears, and if their voices are loud, the politicians must bend to their will. If our politicians are afraid and their voices alleviate our fears, then we bend to *their* will. My point is, it is OK to be afraid. I am a pulmonary and critical care doctor, my wife is a pediatric intensivist, we have a small child, and we are afraid. But to wear a mask is to be brave. To social distance is to be brave. To trust your doctors is to be brave. To those with doubts, know that you are correct in your feeling that the system is broken. I don't know how to fix it, but I know that it has to be done soon. Help us get through this so we can build a better world: a world built from understanding, not from fear.

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## Gender & Migraine Mortality

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Prior research indicates that women with migraine are at an increased risk of cardiovascular disease-related mortality, when compared with women without migraine. However, studies assessing whether migraine directly affects all-cause mortality have provided inconsistent findings. "Because women are 3-4 times more frequently affected by migraine than men, my colleagues and I sought to understand whether this disease puts women at higher risk for long-term consequences, such as all-cause mortality," explains Jessica L. Rohmann, PhD-candidate. For a study published in *The Journal of Headache and Pain*, the researchers sought to estimate the effect of non-migraine headache and migraine, as well as migraine subtypes, on all-cause and cause-specific mortality in women.

The research team followed more than 27,000 women with migraine (history of migraine without aura or migraine with aura) or headache for a median of 22.7 years. The team evaluated reported incidence of death and used medical records to determine if the deaths were caused by cardiovascular disease, any cancer, or female-specific cancer causes.

"Our results indicated no differences in all-cause mortality for women suffering from migraine or non-migraine headache compared with individuals without any headache," notes Rohmann. Additionally, no differences in all-cause mortality among migraine subtypes were observed when compared with women without any headache. Women with migraine and aura had a higher mortality rate due to cardiovascular disease but were less likely than other women with migraine to die of other causes.

"These results should be reassuring for women with migraine, as this disease does not appear to result in an increased risk of all-cause death," says Rohmann. "Our findings corroborate results from previous studies indicating an increased risk of cardiovascular disease-specific death, specifically those women who reported migraine with aura. Thus, treating physicians should consider the vascular risk profile of women with migraine with aura and, if needed, provide preventive suggestions related to modifiable vascular risk factors."

Rohmann believes future studies should focus on understanding how migraine pathophysiology might interfere with the vascular system to develop better prevention strategies for women with migraine with aura. Additionally, whether the findings of this study can be extended to men with migraine remains to be seen.


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