PHYSICIAN'S WEEKLY
RHEUMATOLOGY
Vol. III • Issue No. 10 • October 2020
WWW.PHYSICIANSWEEKLY.COM

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.

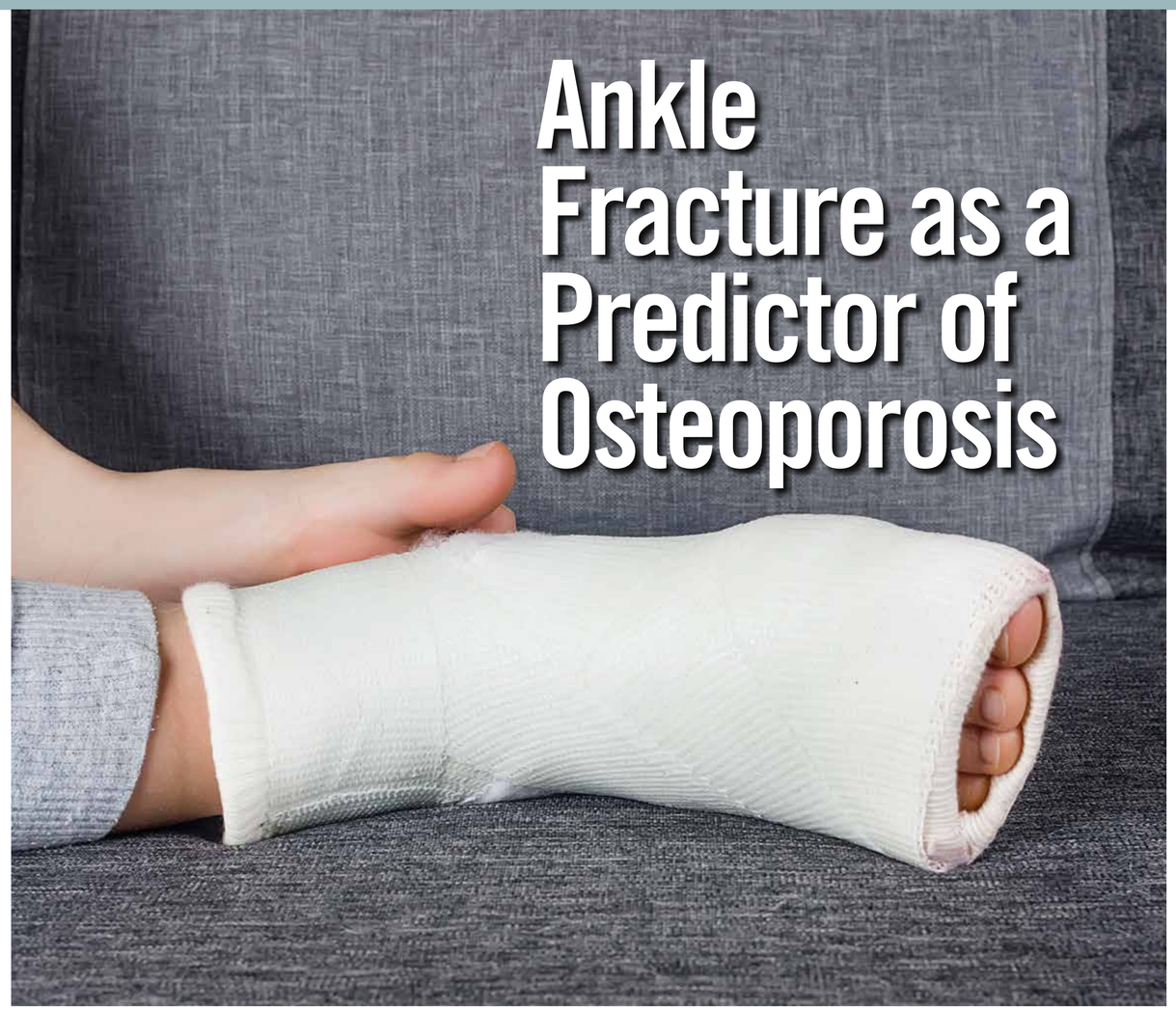
The standard during this waiver is one of good faith. If PHI is intercepted during transmission but the practitioner followed the OCR's guidance, there will be no penalty. Note, however, that states often have stricter regulations, and the federal waiver does not affect these.

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.



Ankle Fracture as a Predictor of Osteoporosis

Written by
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Evidence indicates that ankle fractures are becoming increasingly more common among older people, presenting a significant burden to the US healthcare system, with annual costs exceeding $17 billion for osteoporosis-related fractures, explains Eric So, DPM. "The injury pattern can be quite complex due to the poor bone quality—a proven risk factor for surgical failure and postoperative complications—and strength," he says. "Assessing bone mineral density in elderly patients who suffer ankle fractures can be an important consideration in the perioperative management of an ankle fracture."

Comparing BMD

With inconsistent findings from prior research regarding the relationship between ankle fractures and osteoporosis, Dr. So and colleagues conducted a systematic review and met-analysis of observational, cross-sectional studies of high methodological quality in order to quantify the relationship between BMD in elderly patients with ankle fractures compared with that of cohorts without ankle fractures. In the final meta-analysis, seven studies were included that measured BMD using dual-energy X-ray absorptiometry. In all seven, postmenopausal women, women older than 50, or patients with a history of fragility fracture of the ankle were compared with a control group of women older than 50 or healthy postmenopausal women without a history of fragility ankle fractures. Among more than 25,000 patients, the average age was approximately 65.

Results of the meta-analysis indicate that patients with ankle fractures had a reduced BMD when compared with health controls of similar age, with an effect size of 0.34 (Figure). Whereas BMD measurements of the lumbar spine, total hip, and distal one-third radius were not associated with ankle fractures, an association was determined between low BMD at the femoral neck and ankle fracture in the studied patients. "It should be noted that this study does not establish a causal relationship, but rather an association," adds Dr. So. "However, this relationship should be studied further. Clinicians with a strong interest in osteoporosis should be aware that elderly patients with ankle fractures may benefit from bone density screening." He notes, however, the variability in association with ankle fractures depending on the anatomic site.

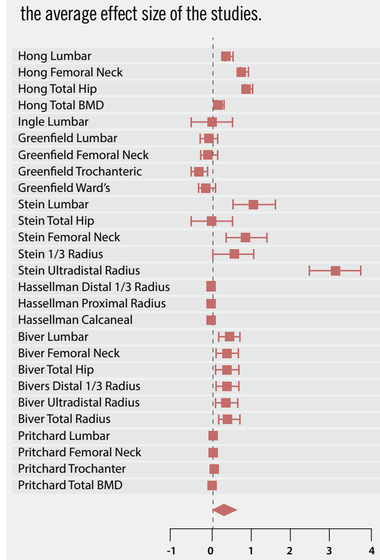
A Screening Process for Undiagnosed Osteoporosis?

"The presence of an ankle fracture in the elderly could be an indicator of potential bone fragility similar to other typical fragility fractures," Dr. So explains. "Its occurrence is a clinical opportunity to assess fracture risk in the elderly population. The implications from our study form the basis to perform further testing, which may prevent subsequent secondary fractures. Currently, fracture liaison services typically do not include ankle fractures as a clinical event that would warrant further bone density testing. Our results could be used to assign the appropriate subgroup of patients with ankle fracture to treat the ankle fracture, assess future fracture risks, and serve as a stimulus for secondary fracture prevention by limiting gaps in anti-osteoporosis initiation. In essence, this data can used to help form the basis for a screening process for undiagnosed osteoporosis, akin to current clinical screening guidelines for colonoscopies or mammograms."

Dr. So notes that this research was the first to quantify the relationship between ankle fractures among elderly patients and BMD, and that while a mild association was seen with a low femoral neck bone density, further research is required. "Future investigations should be focused on determining the percentage of elderly ankle fracture patients with undiagnosed osteoporosis by obtaining bone density at the time of ankle fracture occurrence," he says. "Other investigations should focus on assessing fracture risk and analyzing the cost effectiveness of osteoporosis screening for ankle fractures in elderly patients."

Figure BMD Variables

The figure is a forest plot for all possible BMD variables, with each study represented by a line indicating the confidence interval; squares on the line representing mean differences, risk differences or risk ratios; and the black diamond at the bottom showing the average effect size of the studies.



Source: Adapted from: So E, et al. *J Foot Ankle Surg.* 2020;59(5):P1049-P1057.

MEDPAGE TODAY's
KevinMD.com
Social media's leading physician voice

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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Assessing Beyond DXA in Older Adults With Fractures

Contributor
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Although dual-energy X-ray absorptiometry (DXA)-measured BMD at the hip and spine is widely used to diagnose osteoporosis, 10%-20% of patients who sustain osteoporosis-related fractures are reported to have normal BMD at these sites, explains Sindhura Bandaru, MD. "Some guidelines suggest that presence of a fragility fracture is diagnostic of osteoporosis, but what constitutes a 'fragility' fracture has challenges," adds Dr. Bandaru. "Many guidelines recommend pharmacologic therapy with osteoporosis drugs for patients with fracture without need for BMD measurement, thus implying that these individuals have osteoporosis, but data documenting that osteoporosis medications reduce fracture risk in those with normal BMD as measured by DXA are very limited. Despite DXA being accepted as the gold standard for clinical osteoporosis diagnosis and treatment monitoring, it has important limitations. Therefore, my colleagues and I sought to explore whether older adults with fractures but normal DXA-measured BMD have normal bone when additional clinically available skeletal health assessments are considered."

Dr. Bandaru and colleagues reviewed data on 387 patients who underwent spine and hip DXA, 8.3% of whom had normal spine/hip BMD reported. In this subset, clinically available bone data—including 0.3 and ultradistal radius T-scores, trochanteric T-scores, lumbar spine trabecular bone score, L1 opportunistic CT Hounsfield units (HU), and femoral cortical index—were assessed. Two or more of these additional bone studies were available in 28 of 32 patients, among whom approximately 80% were identified to have abnormal values at two or more sites. "Among all the skeletal assessments considered, the highest yield of identifying abnormal bone was with the opportunistic CT L1 HU and radius (0.3 and UD) DXA T scores, which were about 80% and 86%, respectively," adds Dr. Bandaru. Among all participants, only 1.3% could not be identified as having abnormal bone using data available in the EMR.

"Our study findings demonstrate that patients with normal spine and hip BMD who sustain fracture rarely have normal bone when all the available data are considered," Dr. Bandaru notes. "These data indirectly support the recommendations that postmenopausal women and men aged 50 and older with a hip or vertebral fracture should receive osteoporosis medication, as their bone is rarely normal."