Telemedicine Update: Consumer Technology, Industry Trends Continue to Drive Changes

A number of challenges and uncertainties—some perhaps more perceived than actual—continue to confront the use of telemedicine. In examining trends in healthcare, however, many paths forward lead to increased telemedicine adoption by providers and utilization by patients.

As reimbursement trends continue to shift to incentivizing the delivery of value over volume, the use of telemedicine will become an increasingly attractive option for healthcare systems, as well as individual providers and clinics competing for the same patients. Additionally, by improving the efficiency of healthcare delivery, telemedicine may be a key factor in addressing the ever-growing demand for healthcare services, which must be met by a shrinking number of providers.

Consumer technology is also driving wider availability of telemedicine. With the continued proliferation of mobile devices and applications capable of providing high quality audio-video communication, along with the capability of wearable devices to collect a growing myriad of health-related data, the virtual distance between providers and their patients is shrinking. As an example, the latest wearable devices can generate an electrocardiogram, similar to a single-lead ECG, with the potential of detecting atrial fibrillation.

As patients and providers become more comfortable with technology for remote monitoring and communication, patients' desire to obtain healthcare services via telemedicine will continue to grow. In some demographic segments, this desire for remotely receiving healthcare has already converted into an expectation that providers offer the option of telemedicine to their patients. If such an option is not available, it is becoming increasingly likely that certain patients will choose another provider offering telemedicine. Indeed, in the 2016 Connected Patient Report by Salesforce Research, a survey of over 2,000 adults, 52% of millennials (18-34) surveyed responded that they would choose a primary care doctor offering virtual care options over one that does not. Additionally, almost 80% of respondents across generational segments indicated they desired for their physicians to have access to health data from their wearable devices.

Employers are also playing a role in encouraging the use of telemedicine. The National Business Group on Health's Large Employers' 2018 Health Care Strategy and Plan Design Survey of 148 large employers showed that 96% of surveyed companies offered a telemedicine benefit to their employees. With the reported per-employee healthcare cost

of $14,000 per year in 2018, these large organizations realize the potential of using telemedicine as a way to significantly reduce the cost of healthcare. This survey also revealed that only 20% of large employers offering a telemedicine benefit reported an employee utilization rate of 8% or more, indicating a significant potential for growth in this segment. Another area for substantial growth is in small and mid-sized employers. According to a 2017 Society for Human Resource Management survey of over 3,000 employers, most employing less than 500 employees, only 34% were offering a telemedicine employee benefit. This number was 23% in the 2016 survey and was even not surveyed in prior years.

As technology and employer benefits make telemedicine more accessible for patients and providers, the level of comfort on both sides of the telemedicine visit should increase, particularly with a provider familiar to the patient. An online survey of over 4,000 patients conducted in 2015 indicated that while only 4% of the survey respondents had participated in a video telemedicine visit, over half indicated they would be willing to see their provider by telemedicine.[1] Perhaps more interesting, only 19% indicated that they would be willing to see a provider at a different group by telemedicine.

Despite the growing demand for telemedicine on the patient side, a 2018 survey[2] of over 600 primary care and specialty physicians by the accounting firm Deloitte indicated that only 14% of physicians have audio-video capability for telemedicine visits and only 18% plan to add the capability within the next two years. Two of the leading reasons cited in the survey for why providers hesitate to adopt the technology—medical errors (36%) and data security/privacy concerns (33%)—can be addressed with becoming familiar with the technology and putting procedures in place to minimize these risks. Paradoxically, the survey also revealed that 9 out of 10 physicians recognized the benefits of virtual care technologies.

The lack of clear reimbursement parameters for both private and public payers remains one of the biggest challenges to widespread telemedicine adoption and utilization. States continue to adopt so-called payment parity laws requiring, at least in principle, commercial health insurers provide similar levels of coverage for services that can be provided in the same manner by telemedicine as in-person. As of 2018, according to the American Telemedicine Association[3], nearly 40 states have a form of a parity law in place or in the legislative process, with some states increasing the scope of coverage of existing laws.

On the public payer side, in April 2018, the U.S. Department of Health & Human Services Office of Inspector General issued a report[4] on CMS telehealth claim payment practices. The report stated Medicare paid a total of $17.6 million in telehealth payments in 2015. This amount is a minuscule fraction of the over $600 billion in total Medicare benefits spending in 2015. Slowly but surely, however, the CMS reimbursement picture continues to improve for telemedicine. Provisions in the proposed CY 2019 Physician Fee Schedule include expanded Medicare-covered telehealth services for reimbursement related to prolonged preventive services.

Telemedicine has been utilized in various forms for many years. What has changed, and continues to change at a rapid pace, is the technology available not only for low cost, high quality audio-visual communication directly between providers and patients but also the development and proliferation of devices that make virtual care even more valuable by providing real-time patient data. As the reimbursement environment becomes more attractive for telemedicine and healthcare trends are continually favoring value and outcomes over visits and volume, providers should be increasingly mindful of their patients' growing desire and expectation for receiving high quality care conveniently and efficiently.

[1]. Welch, et al., Patient Preferences for Direct-To-Consumer Telemedicine Services: A Nationwide Survey, BMC Health Services Research (2017) 17:784.
[2] Deloitte 2018 Survey of US Physicians, "What can health systems do to encourage physicians to embrace virtual care?"
[3] American Telemedicine Association State Policy Resource Center, "States with parity laws for private insurance coverage of telemedicine (2018)," accessed September 20, 2018.
[4] https://oig.hhs.gov/oas/reports/region5/51600058.asp or full report at https://oig.hhs.gov/oas/reports/region5/51600058.pdf

Know Your Medical Record

Know your medical record. It's an obvious statement. It's a simple statement. On the face of it, it shouldn't even be a necessary topic of discussion because it is presumed that we in fact do know our records. But that presumption is rebutted each and every day by reality. The reality of a steady stream of patients, many with complicated and extensive histories. The reality of procedures taking longer than expected, leaving little time for preview or review. The reality of peripheral business and insurance issues that can slow the practice of medicine to a crawl. And lastly, the reality of electronic medical records that have been known at times to make accessing and obtaining correct medical information more difficult. All of these considerations and stresses can leave little time to know the critical bits of information in a patient's chart. Most of the time it is not a problem. But when it does become a problem, the results can be catastrophic. The following three cases illuminate this point.

An expectant 34-year-old mother of one of our insured obstetricians underwent routine screening for Group B Streptococcus, as ordered by the doctor. The OB physician assumed that the test result was transmitted to the hospital. The result was positive and scanned into the patient's EHR, maintained by the doctor, since he ordered the test. The result went unread. On the day of delivery, the vaginal delivery was performed as though the result was negative because they did not have instructions to the contrary. The doctor assumed the result was negative because the hospital scheduled it as a routine vaginal delivery. The chart, with the positive test result, was readily accessible in the hospital prior to the birth. The chart was again not reviewed by the doctor or hospital staff. Mom had an uneventful delivery of a male baby, and both were discharged home in due course. However, the mom returned the day after discharge when her baby began suffering seizures. It was then that the doctor saw mom's positive Group B Strep test, and the male baby was diagnosed with sepsis and meningitis. After a prolonged hospital course, he was discharged to return home. A lawsuit was then filed against the obstetrician and the hospital. Litigation took some time, however, as the extent of the damage to the child could not be determined until more time passed. The child had some fairly severe neurological deficits from the untreated Group B Strep, and a settlement was reached by all defendants prior to trial.

A 29-year-old male patient presented to a gastroenterologist with a laundry list of abdominal issues including diverticulosis and irritable bowel syndrome. The patient was new to the area and was establishing care. At this visit, the patient noted on his new patient questionnaire that he had Ehlers-Danlos syndrome, a connective tissue disorder. He had some mild complaints, which were treated conservatively. The patient returned less than five months later, this time complaining of more severe abdominal problems, including bloody diarrhea. Due to the patient's extensive history, the doctor scheduled an immediate EGD and colonoscopy. On the pre-procedure form, the patient failed to note that he had

Ehlers-Danlos. The procedures went well and the patient was sent home. Later that evening, the patient called the office stating that he was vomiting and had some abdominal pain. The doctor prescribed Phenergan and set up an appointment for the next day. Before the patient could be seen, he went into cardiac arrest and suffered brain damage. It was later determined the patient's duodenum had been perforated during the procedure. The lawsuit that soon followed alleged that the doctor should have been more aggressive in treating the patient's post-procedure complaints since the initial intake form mentioned the connective tissue disorder. The gastroenterologist relied on the patient-completed questionnaire and failed to review his own record, which included the history of Ehlers-Danlos Syndrome. The defense countered that the patient failed to note the syndrome on the pre-procedure form, but a jury agreed with the patient's contention and rendered a significant verdict against the doctor.

A pediatrician referred his young male patient to a local ENT due to continuing issues with upper respiratory tract infections. At the initial visit, the parents noted that their son also suffered from frequent restless and noisy breathing while sleeping. The ENT sent the child for a study to determine if he had sleep apnea, which would dictate the best place for him to have his surgery. In the meantime, surgery to remove his tonsils and adenoids was scheduled at the ambulatory surgery center. If the study confirmed sleep apnea, the surgery was going to be moved to the nearby hospital. The study did confirm that the young boy had sleep apnea. This finding was placed, unread, in the doctor's chart. A few weeks later, the adenotonsillectomy took place at the ambulatory surgery center. After the ENT completed what appeared to be a routine procedure, he left the patient with the anesthesia team to awaken the boy and discharge him home. The problem was, the child did not awaken easily. The anesthesia team administered oxygen via an ambu bag and a mask. Eventually, they administered Narcan. Everyone involved was still unaware of the sleep study finding of apnea. No thought was given to transferring the child to the hospital. Finally, the patient was stable enough to send home. Later that night, the parents found their son with a bluish color and in respiratory distress. The child was rushed to the ED and resuscitated. He was admitted for an extended stay but passed away. An attorney for the family alleged that the procedure should have never taken place in an ambulatory surgery center based on the sleep apnea. It was difficult to refute that contention based on the fact that was the exact purpose of obtaining the sleep study. An out-of-court settlement was reached.

The specialties and procedures involved in the above cases are all very different. But there is a common theme running through all of them: information was obtained and placed in the medical records, whether it was test results or a questionnaire. In all three cases the information was critical to the rendered treatment. In all three cases the information was not reviewed, leading to devastating consequences. Had there been stronger systems in place to ensure that test results had been received and reviewed, communicated to the patient and follow-up treatment decisions made, the outcomes for these three patients would most likely have been much different.

Informed Refusal

Physicians and other clinicians are well aware of the legal obligation to provide informed consent for treatment. A fundamental component of consent is providing the patient with sufficient information to make an informed decision about the risks, benefits, and alternatives of the proposed treatment. Clearly, one of the alternatives to treatment is to forgo it altogether. Patients have autonomy with regard to healthcare, and many patients elect to refuse treatment based on a number of factors such as cost, health literacy, fear of a particular procedure, and cultural or religious considerations. When this is the case, it's important to document the patient's reasons for refusal as well as the physician's discussion of the indications for the treatment, consequences of refusal, and any follow-up conversations and educational materials provided to the patient. Physicians and other healthcare providers should document using a refusal of treatment form or make other appropriate documentation. Some recent examples of informed refusal claims against SVMIC-insured physicians include the following medical situations:

- A lymph node biopsy revealed metastatic squamous cell carcinoma, but the patient refused radiation or chemotherapy.
- A patient in premature labor experienced hemorrhage from placental abruption but delayed consent for emergency C-section for 10 minutes, resulting in delivery of a stillborn infant.
- An EKG showed a bundle branch blockage, but the patient refused follow-up treatment and cardiology consult.
- An elderly patient with pulmonary hypertension, mitral valve disease, hypertensive heart disease, and atrial fibrillation refused any evaluation or treatment for these problems.
- A patient with a strong family history of colon cancer refused a screening colonoscopy because insurance would not pay for the procedure. The patient was subsequently diagnosed with colon cancer.

All of these cases were resolved successfully due to the fact that there was documented evidence that the patients were provided sufficient information on the risks of forgoing treatment. The important elements of documenting informed refusal include the following:

- Document the patient's reasons for refusal.
- Emphasize that the patient understood the risks of refusing the recommended care.

Try also to obtain the patient's signature on an "informed refusal" form. Several entities including the American Medical Association, American College of Obstetricians and Gynecologists, American Academy of Pediatrics, American Academy of Family Physicians, and others have sample forms, both general and specific, to a particular refusal (vaccines, genetic testing, dialysis, etc.). SVMIC also has a general sample informed refusal form that

may be downloaded here. By using a refusal form, the patient may better appreciate the potentially serious consequences of their decision. If the patient refuses to sign the form, the documentation in the record regarding any discussion(s) with the patient, their reasons for refusing the care and their refusal to sign the form should suffice.

If the patient was referred to the clinic as a consult, be sure to document the above information in a letter to the referring physician.

This documentation may become crucial to avoiding a negligence claim in the event of an adverse outcome. Refusal to adhere to recommended treatment may result in a decision to discharge the patient from practice. Discharging a patient for non-adherence should be a last resort only after inquiring about and attempting to resolve barriers to adhering to the treatment plan. As noted earlier, many patients are unable to afford the medication or recommended testing, do not have transportation, do not understand the care instructions or have other barriers to adherence. It's a patient's right to refuse treatment, but it's the physician's duty to ensure that refusal is well-informed.

If you have questions or concerns, or would like to discuss a particular situation, please call 800-342-2239 and ask to speak to a member of our claims attorney staff.

Chance Encounter Results in Privacy Breach

The following article is based upon an actual claim situation experienced by an SVMIC policyholder. The details have been altered to protect our policyholder's privacy.

What images do the terms "security breach" or "privacy breach" conjure up when you see them? Most people think of ransomware attacks or identity thieves hacking systems and stealing personal information, as these instances are so prevalent in the news. While security or privacy breaches often involve electronic systems, the terms may also apply to non-electronic records.

Dr. Collin James,* a pediatrician, enjoyed practicing in the small community where he and his family also lived. One evening on his way home from a busy day seeing patients, he stopped by the grocery store to pick up some items for dinner. While contemplating the butter selection in the dairy section, a woman approached him with a small child.

The child was a patient of his, and Dr. James recognized his mother and the boy immediately. After greeting them warmly, the mother of the child mentioned that her son was still running a low-grade fever, even though he had taken antibiotics since they saw Dr. James in his office a week ago. She asked him what to do and Dr. James advised that if she was concerned, she should take her son to the emergency department at the local hospital, or if she thought he could wait, she should phone the office in the morning and he would be happy to see her child. She said she would think about it and would probably call him in the morning.

Dr. James asked the woman to remind him of her child's date of birth and full name so that he could let his office staff know to check on her son in the morning if they have not heard from her. He wrote this information along with a quick summary of their conversation on the back of his grocery list, with the intention of adding notes regarding this encounter into the boy's medical record as well as following up with the patient.

Once Dr. James got home and unloaded the groceries, he proceeded to log in to his laptop and access the office medical records to enter his notes. He looked in his pocket where he had kept his grocery list, and it was not there. He took all of the grocery bags out of the recycle bin and checked for the note there, to no avail. He traced his steps back to the car and looked all over the car, including the trunk, but he could not find the note.

He returned to the store, scanning the parking lot and then searching throughout the store but could not find the note anywhere. Dr. James remembered the name of the child, but recognized the possible ramifications of the disclosure of protected health information,

which included the child's full name, date of birth and notes regarding his condition.

As soon as Dr. James got to the office in the morning, the first thing he did was to ask his staff to follow up with the patient. The second thing he did was call SVMIC, since he knew his coverage included $50,000 of cybersecurity insurance coverage.** He spoke with an SVMIC claims attorney, who then forwarded the information to NAS Insurance, SVMIC's partner in cybersecurity coverage.

The cybersecurity coverage included coverage for "a claim for an actual or alleged security and privacy wrongful act." A "security and privacy wrongful act" as defined in the endorsement is "the failure to prevent or hinder a **security breach**, which in turn results in…the theft, loss or unauthorized disclosure of electronic or **non-electronic** confidential commercial, corporate, personally identifiable, or private information that is in an insured's care, custody or control." NAS was able to assist Dr. James in determining how he should proceed in mitigating any damage caused by the lost note, including notification of the patient.

In addition to the cybersecurity coverage through NAS provided in SVMIC's medical professional liability policy, there are other tools available to our policyholders. Through SVMIC's partnership with NAS, our policyholders have access to NAS cyberNET. This site features monthly cybersecurity updates, webinars and online training and support. Access this site here. In addition, SVMIC's Medical Practice Services offers consulting and training related to cybersecurity and HIPAA.

All names have been changed

** Cybersecurity coverage is subject to terms, conditions and exclusions not described in this article. The information contained in this article concerning cybersecurity insurance is intended to give you an overview of the coverage available. None of the information—including any policy or product description—constitutes an insurance policy or guarantees coverage. The policy contains the specific details of the coverages, terms, conditions and exclusions and coverage determination is made by the company at the time of a claim.

Some Physicians Receive Alterations to 2017 QPP Scores

The Centers for Medicare & Medicaid Services (CMS) updated the 2017 Quality Payment Program (QPP) performance scores for some participants. Released in mid-September, the updated feedback will impact Medicare payments in 2019. The scores were changed based on the CMS' review of several program variables, to include the hardship exceptions for Extreme and Uncontrollable Circumstances. CMS extended the review deadline to October 15, so please review the accuracy of your scores in the interim. If you need assistance in obtaining or interpreting your scores, contact the QPP Service Center by phone at 866-288-8292 or by email.

It's Due Time: Patient Self-Scheduling

Blame OpenTable®, Uber®, or ATMs, but the world of self-service is knocking on physicians' door as patients desire self-service tools. Patient self-scheduling solutions need not encumber your practice; in fact, they can be an excellent way to reduce a burden on your already-overworked administrative staff. In addition to freeing up some staff time, self-scheduling can benefit your practice by:

- Allowing cancelled slots to convert to arrivals; for example, on Tuesday morning, Ms. Smith cancels her long-scheduled Friday morning appointment, while Mr. Jones self-schedules in that now-available slot on Wednesday. That appointment slot may have otherwise gone unfilled.

- Reducing no-shows, as patients are in charge of their appointment – and can better reference their personal calendars when choosing the right date and time.

- Permitting access to the functionality 24/7 and (typically) via a mobile device, allowing working professionals a better shot at obtaining an appointment – perhaps encouraging a younger, more commercially insured patient population to access your practice.

- Integrating appointment confirmations, allowing patients to have documentation of their appointment date and time, and, if applicable, providing a convenient link to your location to improve patients' timeliness of arrival.

- Engaging patients in other self-service tools that could improve your efficiency, such as notification of normal test results.

While there is fear of the unknown, there's no reason you have to convert your entire appointment schedule to a self-service option. Look for a solution that puts you in charge of managing this offering, which can be limited to only certain time slots (for example, in the afternoon), as well as particular types of patients (for example, exclusively established patients – or only a cohort of patients, such as those seeking a flu shot). Many products offer integrated, rules-based decision trees to ensure that the "wrong" patient doesn't end up in the "wrong" slot – and remember that you can still monitor the schedule just as you

do today with the current phone-based model.

Just as many in the industry transitioned to automated phone and text-based reminders in the past several years, medical practices are recognizing the value of patients self-scheduling. 2019 is the year of digital transformation for medical practices. Self-scheduling solutions are readily available; take the opportunity to determine if this is a solution that could meet the needs of your patients – and your practice.