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Covering Practice and Risk Management Issues for Health Professionals

What You Should Know About Telehealth

BY KATHERINE L. GREGORY, MD, MPH

If you attended the PRF annual meeting in April, you heard a great deal about the use of audio-visual ("AV") technology in the delivery of health care services, now known as "telehealth." While we think of telehealth as a new concept, in fact physicians have been practicing some form of telehealth for decades. We have been providing advice to our patients by phone, fax, emails, and, more recently, live video conferencing.

There is some discrepancy about the definition of telehealth. The Medical Board of California defines telehealth to include only AV technologies or "store and forward" technology to provide or support health care delivery. The Medical Board does not include telephone, email, or fax in its definition of telehealth. On the other hand, California law (i.e., California Business and Professions Code 2290.5) is not as clear and does not specifically exclude phone, email, and fax from the definition of telehealth.

Telehealth is *not* a separate specialty and differs from health information technology ("HIT"), which refers to electronic medical records and storage of health information.

Like most areas of technology, telehealth has a bit of its own jargon. Here a few terms to become familiar with:

- **Synchronous:** This is two-way live video found in smart phones, iPads, wireless tools, etc.
- **Asynchronous:** Also known as "store and forward," this is the transmission of a patient's medical information from an originating site to the health care provider at a distant site without the presence of the patient. Examples include:
  - transmission of still images, such as those in radiology and pathology
  - consumer-driven technology, such as remote monitoring of vital signs, blood glucose, and weight
- **Originating Site:** This is the site where the patient is located during a telehealth visit.
- **Distant Site:** This is the site where the provider is located during a telehealth visit.

While the purpose of this article is to make our members aware of some key recommendations for providing telehealth services, we should start by reviewing some of the benefits.

TELEHEALTH BENEFITS

Some of the benefits of telehealth are:

- Efficiency
- Increased access to care
- Convenience for the patient
- Improved safety and quality of care

Efficiency

In a busy physician's office, exam rooms are considered prime real estate and often are full to capacity. By incorporating telehealth into a practice, a physician or nurse can conduct visits from a computer station or consultation office, thereby increasing productivity during any given day. In the area of chronic care management, more frequent follow up with patients is easily done with the patient in her home. While it is still important to conduct a HIPPA–compliant visit and consider privacy, it does not require the use of an exam room, which can be used for another patient.

Increased access

Several organizations have used telehealth to provide increased access to care, especially in rural areas. The UC Davis telehealth system provides telehealth service to all of Northern California, an area equivalent to the state of Pennsylvania. Other international organizations provide telehealth on several continents to remote parts of the world. Other organizations rely on telehealth, such as Mavenproject.org, which was started by another PRF Insured, Dr. Laurie Green, to bring together volunteer U.S. physicians to provide free care to the underserved.

Convenience

Patient demand for more convenient health care has been the driving force for many telehealth start-up companies. Patients are

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willing to pay out of pocket for telehealth visits in order to avoid loss of work, and this need has spurred a multibillion dollar industry. Parents can now have an after-hours visit from their own home with a pediatrician to discuss their child's symptoms. There are also e-tools such as EKG devices and electronic otoscopes to transmit images, which enhance the potential of telehealth visits.

Quality of care and safety

Imagine the value of keeping patients with infectious diseases such as the flu home instead of in your waiting room! Studies in the areas of CHF and diabetes management have shown more frequent contact with patients results in fewer re-hospitalizations and overall better quality of care.

TELEHEALTH ACCREDITATION

If you are interested in providing telehealth care, you should be familiar with the American Telemedicine Association ("ATA"). Founded in 1993, the ATA is a non-profit organization with individual practitioners, large health systems, private companies, and international organizations as members. The ATA has developed clinical standards for a variety of specialties as well as technical standards for companies that are competing in this space. Also, the ATA provides an accreditation process, which serves as a stamp of approval that the company is legitimate and complies with the federal HIPPA regulations.

BASIC TELEHEALTH CAVEATS

Standard of Care

First and foremost, providers of telehealth are held to the same standard of care regardless of whether they are caring for the patient in their office or via a telehealth visit. In other words, if the patient requires an exam for a proper diagnosis, that patient must be examined by a provider, but not necessarily the clinician providing the telehealth service. For example, CVS Minute Clinics are staffed by nurse practitioners who can examine the patient while the physician is observing the exam by video at a distant site. Along the same lines, physicians cannot prescribe medications without an appropriate prior examination justifying the patient's use of the drug. It is also important to reiterate that all laws regarding the confidentiality of health care information and a patient's rights to his or her medical information apply to telehealth interactions.

Consent

Physicians must document either verbal or written consent for each telehealth visit. Some states require an initial in-person visit before a physician can conduct telehealth visits with a patient, and other states require written consent. However, California only requires that verbal consent be obtained and documented.

Licensing

While there are more than a dozen states participating in cross-border licensing, California is not one of those states. Physicians must be licensed in California in order to provide telehealth to patients residing in California. There is an exception to this rule: an out-of-state physician may act as a consultant to a California-licensed physician with regard to a patient's care. However, the out-of-state physician may not provide direct care or prescribe medications for the patient. Conversely, physicians who practice in California must be licensed in each state where they provide the telehealth service. Exceptions to this rule are the Veterans Administration and Department of Defense systems. One of the first criminal prosecutions was of a Colorado physician who was sentenced to nine months in jail for conducting a telehealth visit and prescribing Prozac to a Stanford student who later committed suicide (*Christian Ellis Hageseth, Petitioner v. The Superior Court of San Mateo County, Respondent*, Case No. A115390, 2007).

Professional Liability Coverage

California physicians need to make sure their liability insurance covers all the regions where the physician provides telehealth care. PRF is only licensed to conduct business in California and therefore can only provide coverage for telehealth services within California. There may be a few exceptions, so any physician providing telehealth services outside of California should contact PRF to ensure there is coverage.

CHOOSING A TELEHEALTH SERVICE PROVIDER

Describing specific companies and reimbursement for visits is beyond the scope of this article. There are numerous telehealth companies with variable platforms, services, and costs. When choosing a telehealth company, it is important to be certain that they have a HIPPA-compliant platform. Other considerations are:

- Where is the visit documented—in the company's or your chart?
- What happens to the patient's record if you discontinue service with the company?
- Does the company provide tech support 24 x 7?
- Do they provide training for both providers and patients about how to use their system?
- How do they confirm identities of both providers and patients?

There is no question that telehealth will play a significant role in how we deliver health care in the future. While there is great enthusiasm about the benefits of telehealth, few payers reimburse for this service. If you think telehealth has a role in your practice and you have any questions about risk management, we encourage you to contact PRF. ■

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Arbitration: What, Why & How

BY SHANNON R. GATES, ESQ.

PRF's Contract of Insurance requires Insureds to make a good faith effort to have every patient sign PRF's Arbitration Agreement. This article explains what an arbitration agreement is, outlines its benefits and legal requirements, and answers some frequently asked questions.

WHAT IS ARBITRATION?

Arbitration is a legal proceeding where an arbitrator determines the resolution of a matter instead of a jury. PRF's Arbitration Agreement provides for a panel of three arbitrators so that the doctor and patient each choose one arbitrator and they, in turn, agree on a neutral third arbitrator. The arbitrators' decision is final and cannot be appealed, except in rare circumstances.

Arbitration has several advantages over a jury trial. Arbitration is confidential, arbitrators generally have a better understanding of the medical and legal aspects of a claim than juries, and arbitration means less time away from the office as scheduling is more flexible and arbitrations are typically shorter than jury trials.

HOW DOES AN ARBITRATION AGREEMENT WORK?

An arbitration agreement is a contract signed by the doctor and the patient in which both parties agree that any disputes between them will be settled by arbitration, as opposed to a jury trial. A new patient should sign an arbitration agreement at the first office visit.

Patients who are concerned about signing the agreement may be given a **Patient Explanation Sheet** (enclosed with this newsletter) and can be advised of the following:

- The patient participates in the selection of arbitrators.
- The arbitrators have the same power to award monetary damages as a judge or jury so the patient is not giving up the right to seek compensation for damages.
- The arbitration process is similar to the court process except that proceedings are more informal.
- Arbitration is generally faster than a court proceeding.
- Once the agreement is signed, the patient has 30 days to rescind the agreement.

Keep in mind the welfare of the patient is always the top priority. In an emergency situation, it is not appropriate to ask a patient to sign an arbitration agreement.

WHAT IS REQUIRED OF A VALID ARBITRATION AGREEMENT?

California law requires three things for an arbitration agreement to be valid in a professional negligence matter:

The first article of the contract must contain the following: "It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration."

The agreement must contain the following immediately before the signature line of the contract in at least 10-point, bold, red type:

"NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE 1 OF THIS CONTRACT."

Finally, both parties must sign the Arbitration Agreement. If any of these requirements are not met, the arbitration agreement is not valid.

CAN THE ARBITRATION AGREEMENT BE SCANNED AND THE ORIGINAL SHREDDED?

If your office retains only a scanned copy of an arbitration agreement, you must ensure that the scanned version maintains the legal requirements set forth above, that it is fully legible, and that a copy can be printed that also complies with the legal requirements set forth above.

CAN THE ARBITRATION AGREEMENT BE SIGNED ELECTRONICALLY?

An arbitration agreement can be signed electronically if: (1) the electronic agreement complies with the legal requirements set forth above, (2) the patient's signature is written out electronically so the patient cannot dispute that he or she signed the agreement, and (3) a copy that complies with the legal requirements set forth above can be printed.

CAN THE ARBITRATION AGREEMENT BE POSTED ON MY WEBSITE?

While posting the arbitration agreement on your website allows a new patient to review it prior to their first office visit, if the patient prints and signs the agreement, it may not be in color and may not be valid. An arbitration agreement should only be posted on your website if it is clearly marked "NOT AN OFFICIAL VERSION" at the top and "EXAMPLE ONLY" written over the signature lines so the patient cannot print and sign the document.

PRF provides arbitration agreements to our Insureds free of charge. To order arbitration agreements, please use the **Baseline Resources Arbitration Agreement Order Form** (enclosed with this newsletter).

More information is provided in the **Arbitration Explanation Sheet for Physicians and Medical Staffs** (enclosed with this newsletter).

If you have any further questions pertaining to arbitration agreements or the arbitration process, please call the PRF office at (415) 921-0498. ■

Shannon Gates is Claims Administrator for PRF

A New (and Powerful) Way to Think about Thinking

BY ROBERT D. NACHTIGALL, MD

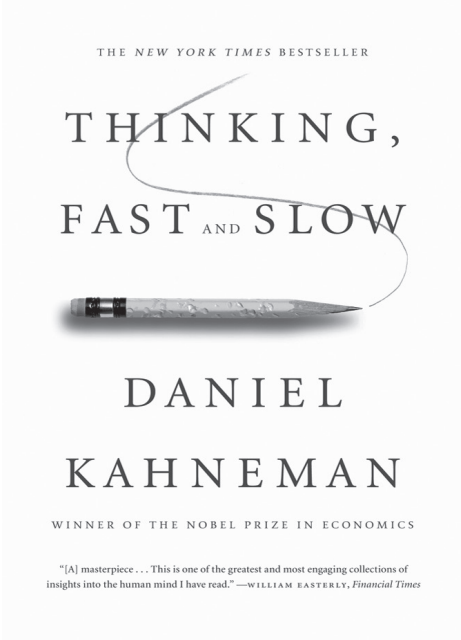
Although *Thinking Fast and Slow* by the Nobel Prize winning economist Daniel Kahneman has been on the non-fiction bestseller list since its release in 2012, I have somewhat belatedly come to the realization that I cannot readily recall another book that has had a more profound effect on the way I view the world in both my personal and professional life.

The underpinning of the book's title (and substance) is Kahneman's paradigm for human thinking; i.e., the interaction and conflict between two different functional thought processes labeled "System 1" and "System 2." (The "Fast" and "Slow" title designations seem to have been made up by the publisher to make this essentially academic book more accessible). Be immediately aware that this conceptualization is a purely intellectual exercise (a "useful fiction" as Kahneman puts it) because there is no attempt to link the "systems" to any real neuroanatomic functions or relationships.

Very briefly characterized, System 1 is ever-vigilant, instantaneous, impulsive, and instinctual—it never rests and cannot be shut off while we are awake. It responds to sensory input with a constant generation of feelings, impressions, intuitions, and intentions. It is our most basic, fundamental, and indispensable survival tool. System 2, on the other hand, is responsible for detailed higher-order intellectual processing and problem solving as well as self-control. Rather than the automatic presence of System 1, it requires conscious effort to invoke System 2.

The interesting wrinkle in this simple formulation is that System 2 is simply (in the author's words) "lazy." System 2 is perfectly happy to let System 1 run the show with the result that you "believe your impressions and act on your desires." The problem is that because System 1 can be so easily fooled, our decisions soon become riddled with inaccuracy and bias unless we consciously invoke the powers of System 2. I personally attest that this takes effort and practice—at least at first.

One hallmark of System 1 thinking is the construction of "stories" to help us make sense of our often unpredictable and sometimes frightening world. These stories may reassure us by providing simple and coherent explanations for people's actions and intentions, but are often based on limited information and gross overestimations of cause and effect. Paradoxically, the less you actually know, the easier it is to construct a story because "there are fewer pieces to fit into the puzzle." Kahneman concludes: "Our comforting conviction that the world makes sense rests on our almost unlimited ability to ignore our ignorance." This conclusion is echoed by the philosopher-statistician Nassim Taleb, who adds that "we constantly fool ourselves by constructing flimsy accounts of the past and believing they are true."



To make the medical connection (and the context for this review) more explicit, Kahneman provides some observations that offer insight into patient and physician biases and vulnerabilities. For example, while the author acknowledges that physician skill can result from years of practice, he argues that the key limiting factor in clinical expertise is whether a medical outcome is sufficiently regular to be predictable. He supports this position by noting that when it comes to prognosticating uncertain events such as the longevity of cancer patients or the risk of sudden death in infants, simple algorithms can match or exceed the accuracy of expert opinion. Yet physicians are well known for assigning an inordinate amount of weight to their intuitive impressions. He says: "The line between what clinicians can do well and what they cannot do at all well is not obvious, and certainly not obvious to them . . . the idea that a mechanical combination of a few variables could outperform the subtle complexity of human judgment strikes experienced clinicians as obviously wrong."

Furthermore, physicians, like all people, are inconsistent in forming conclusions from complex information—experienced radiologists shown the same chest X-ray on two separate occasions will give a different reading 20 percent of the time. Yet physicians' tendency towards overconfidence is actually encouraged by their patients. Kahneman concludes that although "an unbiased appreciation of uncertainty is a cornerstone of rationality – it is not what people want…it is considered a weakness and a sign of vulnerability for clinicians to appear unsure...and there is a prevailing censure against disclosing uncertainty to patients." The (comforting?) irony is that if an algorithm makes a medical mistake people view it so much more negatively than human error that they express a preference for the physician's judgement (even if it is less accurate!) and worry that medicine will become "impersonal" if guided by statistics and checklists.

Despite a best-seller status usually reserved for easy-to-digest and aptly named works of pop-psychology, be forewarned that this is not a breezy read. (That there are *CliffsNotes* versions available on Amazon has to tell you something). And if I characterize this synthesis of a lifetime's research on human decision-making as a dense and scholarly work—please don't take it as a criticism—recognize that this is literally brainy stuff. Trust me, your System 2 will thank you in the end. ■

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