FOCUS FAMILY PHYSICIAN

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A publication of Arizona Academy of Family Physicians

Health Equity

Focus on the Journey, Not the Destination

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ARIZONA ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR ARIZONA

CONTENTS

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Editor's Message

Edward J. Schwager, MD, FAAFP

It is now the third week of August. The Arizona Department of Health Services COVID-19 data website (https://www.azdhs.gov/covid19/data/index.php) shows all Arizona counties have returned to transmission as substantial in most counties (> 100/100,000 population) with other counties at moderate transmission (4-9 cases/100,000 population). Much of the United States is in a similar position, with too many communities (and hospitals) in the South overwhelmed by the current surge. In early July I was among the optimistic group thinking that the country had a lid on this disease. With ongoing vaccinations and people accepting responsibility for others in their communities we would return to something close to pre-COVID-19 activity. Vaccinations have yet to reach a level for herd immunity (which may now need 84% vaccinated due to the increased infectivity of the delta variant). Too often, personal responsibility seems to be, "I'll do what I want" without regard to one's actions' effect of those with whom they contact. One of our governments' responsibilities is to protect and insure the well-being of its citizens. When individuals' choices and actions have great potential to harm others, our governments need to step in. Kudos to our local school boards and community governments who bravely require masking and social distancing in the face of our state's retribution.

Several months ago, I made note that a silver lining of the COVID-19 pandemic was the rapid roll-out of telehealth services, greatly improving patients' access to care. Moving beyond the emergency authorization for telehealth services, the Arizona legislature passed, and the governor signed legislation allowing for the continuation of telehealth services and payment parity to in-person services. I encourage you to review the details of Arizona's new telemedicine laws described by the AzAFP lobbyist, Susan Cannata, JD along with MICA's very important review, Managing Your Telehealth Liability risk.

Also in this issue are updates from our president, William Thrift, MD and resident board member, Kreena Patel, MD. Their summaries make note of our active and engaged leaders focused on improvements for Arizona's family physicians and our patients.

Happy reading. Stay well. And, Mask Up Arizona!

William Thrift, MD, FAAFP, President

Our Mission:
"To enhance the health of the people of Arizona by promoting the specialty of Family Medicine by supporting members' professional development in the scope of service"

This last week (July 2021) 17 board members came together to write our strategic plan. We met at the Dove Mountain Resort in Marana. It is a very nice place to spend a weekend in a conference room with 16 other board members, but still it was a conference room. It was great to see them in person outside of those little Zoom boxes we have been meeting in this last year. With all now vaccinated we even got a few hugs, strange after this strange year.

The last time the board worked on the plan was five years ago. We picked up again on the plan, charting the course for the 2,270 Academy members in Arizona.

The strategic plan establishes priorities for the Academy, guiding the staff in their work. The plan is the map for the future with the board's hand on the rudder, navigating the course for the future. The board's task was to take a broad overview of our direction. We try to direct the staff but then stay out of their way. At times it is difficult to "stay out of the weeds" and micromanage what they do. Nancy, a facilitator from the American Academy of Family Physicians, helped lead the process. She kept us on task but let us do our work.

Our Academy advocates for the family doctors of the State, protecting the practice of Family Medicine so we can serve patients. Our work at the Statehouse is often the voice of primary care in Arizona molding legislation that helps our patients. We bring in the concerns of Arizona family doctors to the national forum at the American Academy of Family Physicians. We have an impact on national policy for family doctors and our patients.

Our Academy furthers the development of Arizona family doctors' continuing medical education and programs that help their practices. We help keep family doctors up-to-date on what's going on in medicine. The Academy assists in education on the practice management for private practice physicians and contracting for employed physicians.

Our Academy encourages the pipeline for Family Medicine residents and medical students' interest groups. We go to universities to inspire students to consider Family Medicine. We help in the recruitment of Family Medicine residents to Arizona. We bring our residents and students to the American Academy's National Conference for leadership training. The people of Arizona need well-trained family doctors to care for them!

It was great to meet with my fellow Board members. Their energy and commitment is inspiring. The future of the Academy and Family Medicine in Arizona looks bright.

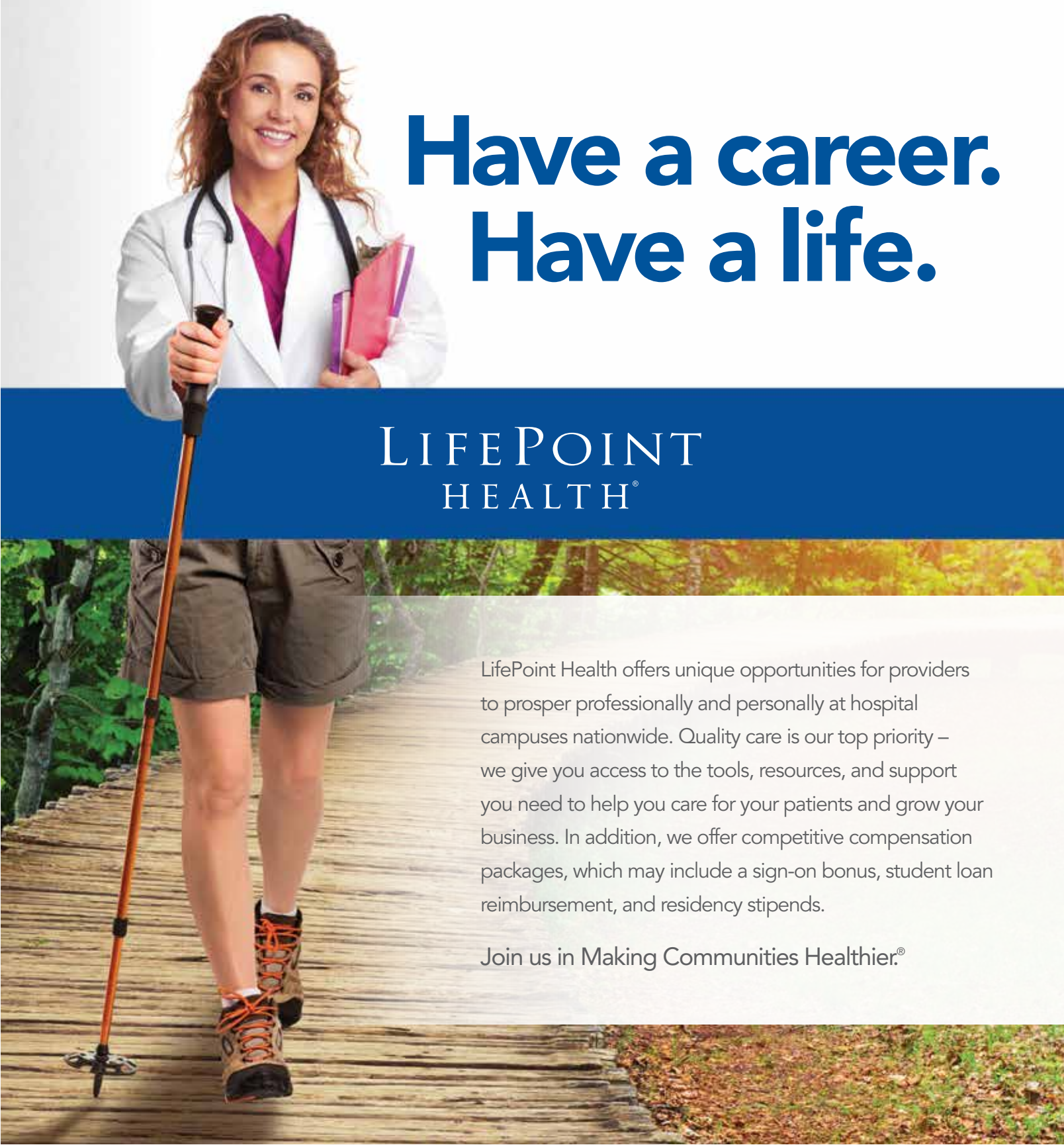
Kreena Patel, MD, MPH

Kreena Patel MD, MPH
Family Medicine | PGY-2
University of Arizona College of Medicine – Phoenix

2021 AAFP National Conference Re-cap

Even though AAFP National Conference was virtual, I really enjoyed participating in the resident Congress. I sat on a reference committee that reviewed resolutions written by residents, and got to be part of pushing forward AAFP policies on important issues such as making telehealth visits count towards residency graduation requirements, and pushing for strong anti-racism efforts from the AAFP. Dr. Heather Merchut and I even wrote our own resolution advocating for more financial literacy education in medical education, which passed successfully! The excitement of molding AAFP policy was palpable even through the virtual platform, and I hope that next year, we will be able to attend in person.

Thanks!



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Focus on the Journey, Not the Destination

Danielle Jones,
Director of AAFP Center for Diversity

With the launch of its Center for Diversity and Health Equity (CDHE) in 2017, the American Academy of Family Physicians (AAFP) established an infrastructure by which it could centralize and operationalize its strategic priority to be a leader on issues of diversity and health equity as they impact family physicians, their patients and the communities in which they serve. At that launch was family physician and former president of the American Public Health Association (APHA) Dr. Camara Jones, who urged the AAFP and attendees of the National Conference of Constituency Leaders (NCCL) in a call to action to address racism as a public health threat. Her guidance to us then was to first name it, identify how it operates and organize to dismantle it. Unbeknownst to us all at that time, we would soon have to do just that. Fortunately, the members and leaders of the AAFP were well prepared.

With the CDHE in place, it didn't take long to implement a process by which progressive policies could be developed and leveraged in the creation of education and training resources to facilitate a transformation in practice and a culture that values diversity and health equity. In rapid succession, the Congress of Delegates (COD) approved policy on Implicit Bias (2018), Institutionalized Racism (2019), required anti-racism and implicit bias training for officeholders and commission members and mandated that the AAFP take an active stance and speak out against racism (2019 Resolution 606). With this fierce momentum, the AAFP kicked off 2020 with the launch of its Implicit Bias Training Guide, a members-only resource created to position family physicians as the lead subject matter experts in their organizations capable of delivering evidence-informed training. In addition, twelve chapters, including California received funding support from the CDHE to develop their own training event not just for their members but also other members of the practice team in coordination with other state primary care organizations. Yet, we and the world would soon be challenged with the twin pandemics of both COVID-19 and racism, the threat Dr. Camara Jones had warned us about just four short years before.

"As a health care organization, the AAFP considers racism a public health crisis. The elimination of health disparities will not be achieved without first acknowledging racism's contribution to health and social inequalities." These were the words of our then president and current board chair Dr. Gary Leroy, and

> "This movement demands that our organization approach issues of social determinants, health disparities, social inequality and racism not merely as subjects of scholarly debate but as calls to action. The patients and communities served by family physicians compel us to act, to lead and to build a better more inclusive and equitable health care system and country."
>
> –R. Shawn Martin, AAFP EVP

in my opinion, marked a turning point for the AAFP. We could no longer ignore that to truly meet our aim of eliminating health disparities and advancing health equity, we had to prioritize racial equity first, starting with ourselves. So, at the direction of our executive leadership, an internal cross-functional staff team was formed to provide direct insight and guidance on immediate and long-term actions the organization could take to advance racial equity for staff, members and other external stakeholders. This team was ambitious, providing nearly 50 recommendations on everything from who the AAFP does business with to the types of imagery we use around our building and at events. While many of the recommendations were implemented immediately, such as the addition of a new floating holiday for staff to observe the cultural holiday of their choice, others would take much more time and planning, which led us to working with an external consultant to advice the organization on further actions to becoming a more multicultural and anti-racist organization.

"Family Medicine was born at a time of great social awareness and with great expectations of making radical changes in society." [1] It is no wonder that family physicians feel compelled at this moment to be the leaders of social change where they live, work and play. As you do so, the Academy is here to support you with policies, education and tools you can leverage in your own organizations.

References

1. Gutierrez, C. and P. Scheid. *The history of family medicine and its impact in US health care delivery*. in *Primary Care Symposium*. 2002.

Updated short BIO

Jones currently directs the American Academy of Family Physicians' Center for Diversity and Health Equity (CDHE). In this role, she guides the strategic priorities of the AAFP's Board of Directors towards a leadership role in addressing issues of diversity, equity, and inclusion across the family medicine specialty. These priorities include diversifying the workforce, establishing health in all policies, developing medical education and implementing practice tools that advance equity. Jones earned her doctoral degree from the University of Kansas School of Medicine in Health Policy and Management where her research on unconscious bias has led to the development of evidence-based curriculum and training for faculty.

**This article was originally published in the Summer edition of the California Family Physician magazine.*

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AGENDA

Thursday, October 14th

- Reproductive Health Care: Conversations for Family Physicians and Their Patients, Sponsored by the CAFP
- AZ Health Public Health Association – Public Health Policy Update, Will Humble, MPH
- Treatment of Hepatitis C in the Primary Care Setting, Ada Stewart, MD, AAFP Immediate Past President
- Legislative Update, Susan Cannata, JD & AzAFP Lobbyist
- Opioid Prevention, Opioid Addiction Resources, Therapies & Current Treatments, Anthony Dekker, DO, Addiction Medicine Specialist

Friday, October 15th

- Course Introduction to POEMS
- Cardiovascular Disease - Gary Ferenchick, MD
- Screening and Prevention - Mark Ebell, MD
- Headache - John Hickner, MD
- Hospital Medicine - Kate Rowland, MD
- Diabetes - Gary Ferenchick
- Pneumonia and Influenza – Mark Ebell, MD
- AAFP Update, Ada Stewart, AAFP Immediate Past President
- Men's Health - John Hickner, MD
- Cerebrovascular Disease - Kate Rowland, MD
- Hypertension - Gary Ferenchick, MD
- Deep Venous Thrombosis & Pulmonary Embolism - Mark Ebell, MD
- Integrative Medicine - John Hickner, MD
- Editor's Choice – All Faculty
- Post Pandemic Party All-Member Awards Reception, Great Wolf Lodge (Pre-registration & Tickets Required)

Saturday, October 16th

- PURLS - Kate Rowland, MD
- Diet & Exercise - Gary Ferenchick - MD
- New Drugs - Steve Brown, MD
- Skin Diseases - Mark Ebell, MD
- Editor's Choice – All Faculty
- Musculoskeletal - John Hickner, MD
- Depression and anxiety - Kate Rowland, MD
- ABFM Update, Dr. David Price
- Practice Guidelines We Can Trust – Gary Ferenchick, MD
- Travel Medicine - Mark Ebell, MD
- Pain Management - John Hickner, MD
- Allergies - Kate Rowland, MD
- COVID drug treatment update - Mark Ebell, MD
- COVID vaccine update - John Hickner, MD
- Clinical Queries – All Faculty

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EVIDENCE ESSENTIALS SPEAKERS

STEVE BROWN, MD

MARK EBELL, MD

GARY FERENCHICK, MD

JOHN HICKNER, MD

KATE ROWLAND, MD

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2021 Legislative Session Brought Big Changes to Arizona Telemedicine Laws

Susan Cannata, JD
AzAFP Lobbyist

Access to telehealth was a top priority for policymakers from both political parties at the Arizona legislature this year. Governor Ducey expanded access to telehealth through an executive order during the COVID-19 pandemic last year and announced at the start of the 2021 session that he wanted the changes to be enacted in permanent law.

That law came in the form of HB 2454 – a comprehensive proposal that expands telemedicine's role in Arizona health care laws. Many health care advocates were involved in shaping the proposal, ensuring it would balance patient access with administrative realities. The Arizona Academy of Family Physicians was an important part of these discussions and supported the bill as it moved through the legislature. It received bipartisan support and became law on May 5, 2021.

Key provisions of HB 2454 include:

The Telehealth Advisory Committee: The bill establishes a Telehealth Advisory Committee to adopt best practice guidelines and make recommendations for the appropriate use of telehealth in its various mediums, including the appropriate use of audio-only telehealth. Physicians represent the majority of members on the Committee, which also includes state agency leaders and other health care representatives. The Committee's report is due by December 1, 2021, but the Committee will continue its work until July 1, 2029.

Telehealth Definition: The new law defines telehealth as "the interactive use of audio, video or other electronic media, including asynchronous store-and-forward technologies and remote patient monitoring technologies, for the practice of health care, assessment, diagnosis, consultation or treatment and the transfer of medical data." This includes the use of an audio-only telephone encounter in specified circumstances but does not include a fax machine, instant messages, voicemail, or email.

Telehealth Services: The law applies to "health care providers" as defined under state law, which includes allopathic and osteopathic physicians, as well as nurses, other health care administrators and professionals, and licensed health care institutions.

Telehealth Service Coverage: The new reforms apply to health plans offered by the following: (1) hospital, medical, dental, and optometric service corporations; (2) health care services organizations; (3) disability insurance; and (4) group and blanket disability insurance.

Telehealth Reimbursements: The bill requires payment parity for audio-visual telehealth services. It also requires payment parity for audio-only encounters for behavioral health or substance use disorder issues. In addition, by January 2022, insurers will cover audio-only services if Medicare or AHCCCS covers the service for audio-only or if the Telehealth Advisory Committee recommends that the services may be appropriately provided by audio-only. Otherwise, payment parity for audio-only encounters is permitted when a physician with an existing relationship with the patient determines that 1) an audio-visual encounter is not reasonably available due to the patient's functional status, lack of technology or telecommunications infrastructure limits; and 2) the patient initiated or agreed to audio-only in advance of the call.

Insurer Limitations and Requirements: Health insurers can only limit telehealth encounters to the same extent that they do in-person encounters, or if practice guidelines, peer-reviewed clinical publications, or the Telehealth Advisory Committee advises against allowing a service by telehealth. The bill requires telehealth services to be covered regardless of where the patient is located or the type of site. Health insurers are prohibited from requiring a physician to use a telehealth platform provided by the insurer, and insurers are not allowed to meet their network adequacy requirements by using contracted physicians who only provide telehealth services and do not offer nonemergency in-person services. Health insurers are also required to reimburse providers for the cost of any waived copayment, coinsurance, or other cost-saving measures that impact the provider's reimbursement.

Provider Telehealth Considerations: Consistent with guidelines adopted by the Telehealth Advisory Committee, the law requires a provider to make a good faith effort in determining both of the following: 1) whether a health care service should be provided through telehealth instead of in-person, using clinical judgment to consider the circumstances of the patient and whether the nature of the services necessitates physical interventions and close observation; and 2) the communication medium of telehealth and, whenever reasonably practicable, the telehealth communication medium that allows the provider to most effectively assess, diagnose and treat the patient.

Delivery of Telehealth Care: The bill allows informed consent to be obtained electronically before telehealth care is delivered. The provider must

inform the patient before the visit if there is a charge for the telehealth encounter. During the visit, a provider must access available clinical information and records. Physicians may write prescriptions after a telehealth encounter. Schedule II drugs may be prescribed only after an in-person or audio-visual examination and only to the extent allowed by state and federal law. All services provided through telehealth or resulting from a telehealth encounter are subject to Arizona law governing prescribing and dispensing of pharmaceuticals, Arizona licensure requirements, and practice guidelines established by the Telehealth Advisory Committee.

Out-of-State Physicians: Governor Ducey prioritized allowing out-of-state physicians to provide telehealth services to Arizona patients, with appropriate protections. As a result, the new law allows physicians not licensed in Arizona to serve Arizonans through telehealth. However, to do so, they must 1) register with and provide specified information and fees to the appropriate Arizona regulatory entity; 2) register with the controlled substance prescription monitoring program if prescribing any controlled substances; 3) hold a current, valid, and unrestricted license to practice in another state; 4) not be subject to any past or pending disciplinary proceedings in any jurisdiction; 5) be in full compliance with laws and rules of Arizona; 6) maintain liability insurance consistent with Arizona requirements; and 7) consent to Arizona jurisdiction for any disciplinary action or legal proceeding related to the care they deliver. An out-of-state telehealth physician registered under the new law cannot open an office in the state or provide in-person health care services to Arizona residents without first obtaining the applicable license.

Providers should consult with their own experts to determine the implications of the new law for their practice.

Visit https://www.azleg.gov/legtext/55leg/1R/laws/0320.pdf to read HB 2454.

Managing Your Telehealth Liability Risk

Supplemental Information & Resources

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Objectives

- Relate Arizona's new & revised telehealth legislation to your medical professional liability risk (MPL)
- Recognize MPL risks in your current primary care telehealth program
- Apply at least one MPL risk management recommendation to your telehealth program

Arizona Telehealth Legislation

- Arizona has 37 single-spaced pages of new & revised legislation
- AzAFP announced Senate passed telehealth bill, with AzAFP support, in E-News Apr 23, 2021
- ArMA offers free report on new telehealth laws HB2454 Report (informz.net)
- ArMA & AZ MGMA potentioanl resources for assistance with payors' telehealth requirements program and encounter requirements
- Level of payment, documentation, fraud prevention, identity verification, deductibles, co-pays, diagnostic & procedure codes
- Coordination with Medicare & Arizona Health Care Cost Containment System
- MICA published Hot Topics in Risk Management Arizona's 2021 Telehealth Expansion Law Jun 16, 2021
- Maricopa County Medical Society & the Arizona Telemedicine Program are offering HB2454 and the Impact for Arizona Healthcare Professionals on Jul 28, 2021, at 2 pm MST. Participants are eligible to earn 1 AMA PRA Category 1 Credit(s)™. Register at https://aztelemedicine.zoom.us/webinar/register/WN_X8xk3YTPSK-5Tl3L0g1xCA
- Today MICA explains the MPL-related revisions & new language

What's New – Telehealth

- Previous legislation defined "telemedicine"
- Telemedicine was the practice of health care delivery, diagnosis, consultation & treatment, & the transfer of medical data through interactive audio, video, or data communications that occur in the physical presence of the patient, including audio or video communications sent to a health care provider for diagnostic or treatment consultation
- New legislation defines "telehealth" A.R.S. § 36-3601(4)(a)
- Telehealth is the interactive use of audio, video, or other electronic medical,
- including asynchronous store-&-forward technologies & remote patient monitoring technologies, for the practice of health care, assessment, diagnosis, consultation, or treatment, & the transfer of medical data includes the use of an audio-only telephone encounter between the patient or client & health care provider if an audio-visual telehealth encounter is not reasonably available due to the patient's functional status, lack of technology, or telecommunications infrastructure limits, as determined by the health care provider does not include the use of fax machines, instant messaging, voice mail, or e-mail
- Includes telephone encounters if physician or health care practitioner determines patient lacks functional status, technology, or telecommunications infrastructure limits & patient requests, initiates, or pre-authorizes encounter A.R.S. § 36-3601(4)(a)
- Except for behavioral health or substance abuse disorder services, existing patient relationship required for telephone encounter
- A.R.S. § 36-3601(4)(b)
- Does not include fax machines, instant messaging, voice mail, or e-mail A.R.S. § 36-3601(4)(c)

What's New – Scope of Practice

- Under the previous legislation
- Exercise care, skill, & learning expected of a reasonable, prudent physician or health care professional in the same or similar circumstance A.R.S. § 12-563
- New legislation
- Exercise care, skill, & learning expected of a reasonable, prudent physician or health care professional in the same or similar circumstance A.R.S. § 12-563
- Telehealth Advisory Committee on Telehealth Best Practices, available in 2022
- See A.R.S. § 20-841.09(A) & (E) (coverage by health insurers & other payors), 20-1507.13(A) & (E) (coverage by health services organizations), 20-1376.05(A) & (E) (coverage by disability insurer), 20-1406.05(A) & (E) (coverage by group disability insurer), 36-3602(E) (physician or other health care practitioner delivers health care through telehealth), 36-3605 (use by physicians & other health care practitioners to determine necessity &appropriateness of telehealth), 36-3607(committee formation, membership, purpose, deadlines)

What's New – Informed Consent

- Previous legislation
- Treating physician or clinician must obtain patient's or patient's representative's verbal or written informed consent
- New legislation
- Treating physician or clinician must obtain patient's or representative's verbal or written informed consent, including by electronic means A.R.S. § 36-3602(A)

continued on page 16

continued from page 15

What's New – Physical/Mental Health Status Examinations

- Under previous legislation physicians could prescribe, dispense, or furnish prescription medication or device after physical or mental health status exam during real-time telemedicine encounter with audio & visual capability
- New legislation permits physical or mental health status exam may be conducted through a telehealth clinical evaluation appropriate for the patient & presenting condition, unless exam is for written certification of adult use of marijuana or falls under an exception
- Also, licensing boards are prohibited from requiring licensees to examine patients in-person prior to issuing prescription A.R.S. § 36-3602(E)
- Schedule II drugs may be prescribed only after an in-person or video exam & only to the extent allowed by federal & state law A.R.S. § 36-3602(E)

What's New – Encounter Type

- Previous legislation was silent
- New legislation requires physician or clinician to determine, in good faith, 2 things
- Need for & effectiveness of telehealth versus in-person encounter
- Application of clinical judgment;
- Patient's need for physical intervention & close observation; &
- Patient's circumstances: diagnosis, symptoms, history, age, physical location, access to telehealth
- Appropriateness of telehealth communication medium for
- Effective for assessment, diagnosis, treatment; &
- Patient's access to, ability or inability to use, limits in telecommunication infrastructure

MPL Risk Assessment & Strategies

- Diagnostic error
- Clinical education & training
- Second opinions & consultations
- Encounter type
- In-person or telemedical
- Expectation management
- Patient experience
- Informed consent

Strategies – Administrative Staff Education & Training

- Current or anticipated telehealth platform
- Managing technical problems
- Use of waiting rooms
- Who to contact & what to do if problems arise
- Verifying identities
- Confirming & documenting who is present
- Practice policies, procedures, processes, forms, checklists, letters
- Online & virtual customer services skills
- Verbal & nonverbal communication
- Role play newly learned communication skills

Risk – Diagnostic Error

- Previous MPL closed claim studies
- Most common MPL allegation in "traditional" MPL claims
- Over 50% of the claims analyzed Special data request provided by MPL Association Data Sharing Project closed claims database (2016-2018). Copyright 2021 MPL Association
- Only 2% of the claims involved telehealth MPL Association (2020). Data sharing project telemedicine 2015-2018. Subscription only. DSP-TELEMEDICINE 2014-2018 (mplassociation.org)
- Now
- Exponential growth in telehealth care volume may increase telemedicine diagnostic error allegations
- Adapting in-person clinical assessment & communication skills to online encounters
- Telediagnosis is the co-production of an accurate & timely explanation of the patient's health problem through remote interactions & transmitted data, including the clear communication of that explanation to the patient through these interactions." Agency for Healthcare Research & Quality. (2020). Telediagnosis for acute care: Implications for the quality and safety of diagnosis, Issue Brief 2, AHRQ Publication No. 20-0040-2-EF, Telediagnosis for Acute Care: Implications for the Quality and Safety of Diagnosis (ahrq.gov), citing Balogh EP, Miller BT, Ball JR, eds. National Academy of Medicine. Improving Diagnosis in Health Care. Washington, DC: National Academies Press; 2015. https://www.nap.edu/catalog/21794/improving-diagnosis-in-health-care
- Telehealth communication & physical examination skills currently in some medical school curricula & post-graduate training programs

Strategies – Medical, Nursing, & Clinical Education & Training

- Conducting virtual physical examinations
- Stanford Medicine Videovisits: Problem-Based Approach to the Provider-Directed Patient Self-Exam Stanford professors of primary care and population health demonstrate how they conduct a physical exam during a telemedicine video visit for three common patient presenting concerns: upper respiratory infections, low back pain, and shoulder pain.
- Taking medical/surgical patient histories
- Current or anticipated telehealth platform
- Managing technical problems
- Use of waiting rooms
- Who to contact & what to do if problems arise
- Telemedicine-specific communication training
- "Mock" telemedicine encounters
- Resources include The Arizona Telemedicine Program (ATP) and the Southwest Telehealth Resource Center (SWTRC) 1-day training courses on telemedicine and telehealth and ATP Telemedicine Grand Rounds

continued on page 18

continued from page 17

Strategies – 2nd Opinions & Consults

- Referral for 2nd opinion or consult
- Tracking & following up on referral
- Reduce potential for telediagnostic errors by utilizing referral tracking & treating a patient referral like a pending laboratory or radiology report: patient encounter "remains open" until appropriate information received whether from lab, imaging center, or specialist.
- One study showed just half of specialty referrals resulted in documented "complete appointments." Weiner M, Perkins AJ, Callahan CM. (2010) Errors in completion of referrals among older urban adults in ambulatory care. *Journal of Evaluation in Clinical Practice, 16*(1):76–81
- A primary care study showed only a 35% "closure rate" for second opinion or consultation referrals. In another study, 40% of referring physicians said "their biggest communication [challenge] was not receiving post-visit care summaries from [referral physicians]." Phreesia. (2021). Rethinking referrals: insights from providers. phreesia-wp-april-2021.pdf (asccommunications.com)
- Checklist or diagnostic time-out
- Experts recommend checklists as self-second opinions. Meyer, A.N., Singh H., Graber, M.L. (2015). Evaluation of outcomes from a national patient-initiated second-opinion program. *The American Journal of Medicine, 128*(10). doi:10.1016/j.amjmed
- Even when the diagnosis seems straightforward, [they] advise that physicians [consider] a 'diagnostic time-out' to step back & review a checklist that may suggest other possibilities—an approach that would tend to counteract almost all of the common cognitive slips." Ely, J.W., Graber, M.L. (2016). Preventing diagnostic errors in primary care. *Am Fam Physician, 94*(6), 426-432. Preventing Diagnostic Errors in Primary Care - Editorials - American Family Physician (aafp.org). Society to Improve Diagnosis in Medicine offers clinician checklists
- Physicians concerned a checklist may deflate patients' confidence in them can explain the benefits of a checklist, enlist their answers, & potentially valuable added information. Id.

Risk – Ineffective Encounter Type

- Potential allegation of negligence
- Negligent choice of telemedicine over in-person appointment
- Potential area of statutory noncompliance
- Need for & effectiveness of telehealth versus in-person encounter
- Clinical judgment
- Need for physical intervention & close observation
- Diagnosis, symptoms, history, age, physical location, access to telehealth
- Appropriateness of telehealth communication medium for
- Effective assessment, diagnosis, treatment; &
- Patient's access to, ability to use, & telecommunication infrastructure

Strategies – Choosing Effective Encounter Type

- Physician or clinician, in good faith, determines, 2 things A.R.S. § 36-3605
- Need for & effectiveness of telehealth versus in-person encounter using legislative criteria
- Application of clinical judgment A.R.S. § 36-3605(1);
- Patient's need for physical intervention & close observation A.R.S. § 36-3605(1); &
- Patient's circumstances: diagnosis, symptoms, history, age, physical location, access to telehealth A.R.S. § 36-3605(1)
- Appropriateness of telehealth communication medium for A.R.S. § 36-3605(2)
- Most effective assessment, diagnosis, treatment A.R.S. § 36-3605(2); &
- Considering patient's access to, ability or inability to use, limits in telecommunication infrastructure A.R.S. § 36-3605(2)
- Documentation of each criterion
- Consider template, checklist, or form with all criteria

Risk – Poor Patient Experience

- Specific to an appointment or phone call or collectively through treatment relationship
- Affected by pre-pandemic & pandemic family, medical, financial, social, education- & work-related, other experiences
- May impact physician's & practice's
- Patient outcomes
- Medical professional liability risk
- Relationships with payors' & their quality incentives
- Financial success

Risk – Informed Consent

- Potential allegations of negligence
- Failure to mention or explain
- Risks
- Benefits
- Alternatives
- Potential area of statutory noncompliance
- No discussion
- No documentation
- Failure to reasonably accommodate known disability
- Failure to consider protected categories, e.g., language, literacy

Risk - Informed Consent Exceptions

- Telehealth interaction does not take place in physical presence of patient
- Emergency in which patient or patient's representative is unable to give informed consent
- Transmission of diagnostic images to consulting or referring health care practitioner

continued on page 20

continued from page 19

Strategies – Informed Consent

- Obtain the patient's or representative's informed consent for telehealth
- Verbal & document A.R.S. § 36-3602(A)
- Written A.R.S. § 36-3602(A)
- Electronic
- Consider template, checklist, or form with required elements
- Consider new informed consent process as practice policies, procedures, or telehealth implementation stabilize or change
- Consider including diagnostic uncertainty. "[Consider] frankly discuss[ing] any diagnostic uncertainty, and make sure the patient knows when and how to contact you if symptoms evolve or do not resolve as expected." Ely, J.W., Graber, M.L. (2016). Preventing diagnostic errors in primary care. Am Fam Physician, 94(6), 426-432. Preventing Diagnostic Errors in Primary Care - Editorials - American Family Physician (aafp.org)

From MICA Hot Topics in Risk Management Newsletter, Mar 24, 2021

Telemedicine Informed Consent: Requirements and Best Practices

Informed Consent Discussion

Telemedicine is new to many. The clinician should explain the risks, benefits, and limitations of telemedicine and address patient responsibilities and expectations. Present the information in terms the patient can understand, so the patient can make an informed decision. The consent discussion process also may increase the patient's comfort with new technology or the change from in-person to telemedicine appointments. Prior to providing telemedical care, physicians and other clinicians should present the following information[1]:

- Basic explanation of telemedicine and the platform being used;
- Benefits – including accessibility, cost savings, and efficiency;
- Risk that a technical interruption could delay evaluation or treatment[2];
- Risk that the clinician's medical decision-making and diagnostic ability may be compromised by the inability to conduct a comprehensive physical exam, lack of access to complete medical records, and/or inadequate image quality;
- Risk of data breach even with the use of security protocols[3];
- Alternatives, such as in-person care;
- Option to decline telemedicine or stop the visit at any time;
- Patient responsibilities, which may include providing complete and accurate information, using a secure network and a private location, and complying with clinician recommendations such as follow up labs, diagnostic tests, referrals, or in-person visit; Federal laws governing privacy and security of health information, as well as patient access to that information, apply equally to in-person and telemedicine care;
- Confirmation of the state where the patient is located during the appointment;
- Billing – confirm there will be a charge for the visit and that patient's share of cost will be governed by their individual insurance coverage,
- Discussion of the practice's telemedicine no-show or cancellation policies; and
- Opportunity for the patient to ask questions.

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[1] For more information about what to include in the consent discussion, consult the American Telemedicine Association's Core Operational Guidelines for Telehealth Services Involving Provider-Patient Interaction (p. 7, numbers 6-8); see also American Medical Association Ethics Opinion 1.2.12, Ethical Practice in Telemedicine, and Federation of State Medical Boards Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine

[2] Clinicians should explain the procedure to follow if a technical interruption occurs.

[3] Always inform patients whether the platform the practice is using meets HIPAA standards.

Indian Health Service is Seeking a Full-Time Primary Care Physician (Family Medicine or Internal Medicine) in Downtown Phoenix, Arizona

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- The 127-bed hospital provides specialty services to both urban and rural tribal members.
- PIMC employs over 1,400 people with additional professional staff traveling throughout the states in the Phoenix Area to provide direct services, consultation, and guidance to other IHS hospitals and health centers.
- The Primary Care Medicine Clinic is an adult based Patient-Centered Medical Home with a satellite pharmacy in the clinic, and access to full scale laboratory and radiology services.

Position Requirements and Benefits

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- 30 minute patient appointments, 16 patients scheduled in a full day (10 hour day)
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Additional Details

- Location: Phoenix, AZ
- Type: Full-time
- Compensation Details: $185,000-$225,000
- Visa Waiver: No

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For more information, Contact:
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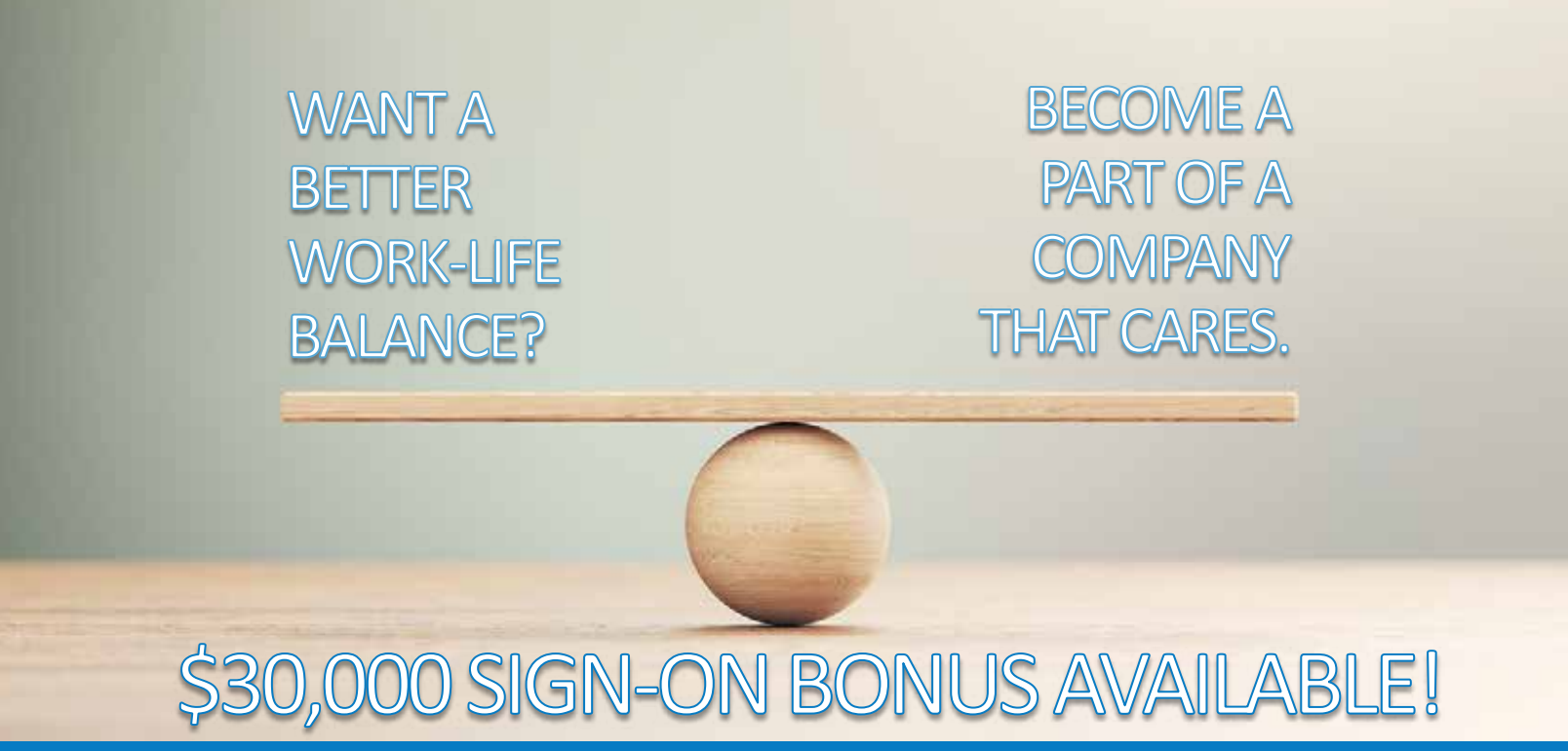

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